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[COMMITTEE PRINT]

MEDICAL APPLIANCES AND THE ELDERLY: UNMET NEEDS AND EXCESSIVE COSTS FOR EYEGLASSES, HEARING AIDS, DENTURES, AND OTHER DEVICES

REPORT

BY THE

SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE

OF THE

SELECT COMMITTEE ON AGING

HOUSE OF REPRESENTATIVES

NINETY-FOURTH CONGRESS

SECOND SESSION

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MEMORANDUM

To: Members of the Subcommittee on Health and Long-Term Care.
From: Claude Pepper, Chairman.
Re: Medical Appliances Report.

As part of its continuing examination of the health care problems of the elderly, the Subcommittee on Health and Long-Term Care has investigated the needs of the elderly for hearing aids, eyeglasses, and dentures as well as the high cost of these medical appliances. The elderly of this nation are entitled to the best health care that is available in the United States. As this report demonstrates, in the area of medical appliances, they are not getting it. There are two reasons: The lack of federal assistance to help the elderly obtain desperately needed devices and the lack of adequate safeguards to protect them from abuses in purchasing these health aids.

An earlier subcommittee report, "New Perspectives in Health Care for Older Americans," recommended that Medicare Part B be extended to cover the cost of hearing aids, eyeglasses, and dentures for the elderly. This report restates that recommendation and provides further documentation of its urgency.

This study is based on testimony presented to the subcommittee at its June 23 and 24 hearings on "Medical Appliances for the Elderly: Needs and Costs." Witnesses at the hearings included Mr. Nelson H. Cruikshank, President of the National Council of Senior Citizens, and Dr. Sidney Wolfe, Director of the Public Citizen's Health Research Group. Other witnesses included representatives of the Federal Trade Commission, the Veterans Administration, the Department of Health, Education and Welfare, Mutual of Omaha Insurance Company, Equitable Life Assurance Society, Prudential Insurance of America, Bausch and Lomb (eyeglass manufacturers), the American Dental Association, the Lumiscope Corporation (distributors of home blood pressure monitoring kits), W. A. Baum, Inc. (manufacturers of home blood pressure monitoring kits), and the National Hearing Aid Society. Additional information has been provided by the General Accounting Office, Carstenson and Associates, the American Speech and Hearing Association, the Ebenezer Society, the Sexton Dental Clinic, the New York City Department of Consumer Affairs, the New York Consumer Services Society, the National Center for Health Statistics, the New York Times, Geriatrics Magazine, Money Magazine, Consumer Reports Magazine, Moneysworth Magazine, Washingtonian Magazine, the Federal Council on the Aging, the Hearing Aid Industry Conference, the American Council of Otolaryngology, the National Association of Blue Shield Plans, the Department of Defense, the General Services Administration, the Indian Health Service, and numerous congressional committees and state health and related departments.

To all of these individuals, agencies, and groups, I wish to extend my thanks. In addition, I wish to thank Mr. Bob Hoyer, Mr. Glenn Markus, Mr. Herman Schmidt, Ms. Jennifer O'Sullivan, Mr. Edward Klebe, and Mr. Henry Cohen of the Library of Congress for providing assistance at every stage of this study.

Finally, I wish to commend and thank Mr. Yosef Riemer, research assistant on loan to the subcommittee from Brandeis University, for his invaluable assistance in the research and preparation of this report. I would also like to thank Dr. Marver Bernstein, President of Brandeis University, for making Mr. Riemer available to assist the subcommittee in this important area.

"They pay but not in dollars. They pay in the quality of life. Some cut down on food requirements. Some go without the proper type of shelter. Some cut off their social life. Many just do without (eyeglasses, hearing aids, and dentures) and fall back into more and more seclusion and live a restricted life because these appliances are not available to them as they should be."

MR. NELSON H. CRUIKSHANK,
President, National Council of Senior Citizens.

"The only way out is to make impossible choices. It is impossible for senior citizens to decide whether or not they want to hear what goes on in the world or whether they want to eat."

DR. SIDNEY WOLFE,
Director, Public Citizen's Health Research Group.

"If we are lucky, we will all grow old. But how frightening to grow old and not be able to see clearly, hear distinctly, or eat properly because we cannot afford the necessary medical appliances to aid our failing facilities."

DR. ROBERT B. LYTLE,
American Dental Association.

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SUMMARY OF FINDINGS AND RECOMMENDATIONS

The well-being of virtually all of the 22.4 million elderly Americans is dependent on one or more medical appliances. Presently the massive needs of the elderly for appliances like eyeglasses, dentures and hearing aids are unmet because, in many cases, the elderly cannot afford the devices and because public and private health benefit programs have provided only limited help in this area. The elderly who are able to afford needed medical appliances are frequently the victims of abuses such as overpricing and unnecessary services.

Vision Care

More than 20 million elderly Americans require and own eyeglasses. However, over five million elderly Americans are wearing glasses which need correction (pp. 5–6).

Serious evidence of abuse has come from a New York survey which demonstrated that one out of five eye examinations given by optometrists resulted in unnecessary prescriptions (pp. 6–7).

Numerous surveys of retail firms selling eyeglasses are conclusive evidence of overpricing. The surveys show a 200 to 300 percent variance in the cost of identical eyeglasses (p. 7).

Medicare does not cover the cost of eyeglasses or related examinations. Medicaid is only slightly more helpful, paying for eyeglasses for those elderly people who are eligible in only half the states. Private insurance companies rarely cover any vision care expenses (p. 8).

Dental Care

Dental problems, such as tooth decay and periodontal disease; are so widespread among the elderly that half of all persons over 65 have no natural teeth (pp. 10–11).

6.2 percent of those elderly people who are without natural teeth also have no dentures. An additional 30 percent of those without natural teeth do have dentures, but they are ineffective and require refitting or replacement (pp. 11–12).

The subcommittee found that identical dentures, including identical fitting procedures, range in price from $100 to $1,000, and concluded that this discrepancy in large part, reflects overpricing (pp. 14–15).

Medicare covers only selected forms of dental surgery, but not routine dental care or dentures. Medicaid programs in 36 states do cover dental care and dentures, but that number continues to decline as many states strive to cut back their expenditures. While dental insurance is the fastest growing line of private health insurance, dental costs remains the least insured major health cost in the United States (pp. 16–18).

Hearing Care

More than one half of all persons over 65 suffer from impaired hearing. For 8 percent of the elderly, the problem is so severe that they are unable to hear words spoken in a normal voice (pp. 19–20).

The hearing aid delivery system, as presently structured, fosters a clear and continuing conflict of interest that pits the profit orientation of the businessmen who sell hearing aids against the health and

economic interests of elderly consumers. Studies have demonstrated that the result of this system of allowing the hearing aid dealers, rather than physicians, to determine the need of elderly consumers for aids, is frequent recommendations by dealers for hearing aids that cannot help buyers (pp. 21–22).

According to three different panels of hearing experts, the training that hearing aid dealers receive is totally inadequate. To compound this problem, many states have no law which set up minimum educational standards that dealers must meet. Many other states do have these laws, but they are often ineffective and frequently lead to the hearing aid dealers regulating themselves (pp. 22–23).

There is almost a total lack of oversight and scrutiny of the hearing aid industry. The Subcommittee heard evidence from the Federal Trade Commission of numerous instances of misrepresentation and anti-trust violations such as price-fixing in the hearing aid industry (p. 23).

The cost of hearing aids is excessively high (two and a half times the wholesale price) and represents a formidable barrier to those elderly people who need the devices (pp. 24–25).

Medicare does not pay for hearing aids at all. Medicaid pays for hearing aids for the elderly in only 11 states. Private health insurance policies rarely cover hearing aids (p. 25).

Prosthetic Devices and Other Durable Medical Equipment

There is evidence of significant overpricing of pacemakers. The Public Citizen's Health Research Group has reported that the actual cost of a pacemaker is "several hundred dollars." Yet, these prosthetic devices generally sell for $1,300. The Department of Health, Education, and Welfare continues to ignore the overpricing and to pay these unreasonably high prices to manufacturers for pacemakers that are purchased by those eligible for Medicare. Pacemakers are big business—endorsed for investment by a reputed Wall Street firm because of 30–50% annual profits—despite Medicare requirements for HEW to reimburse only "reasonable cost." The subcommittee found that since Medicare pays for most pacemakers, patients and doctors are not concerned with price, providing little if any incentive for manufacturers to cut prices (pp. 25–26).

There is also conclusive evidence of the waste of 10 million taxpayer dollars per year because Medicare allows excessive payments, as opposed to cheaper methods of acquisition or leasing of hospital beds, crutches, wheelchairs, and dialysis equipment, that are covered by Medicare. Four years ago legislation was passed authorizing HEW to take the necessary steps to end that waste. Yet, the Department has progressed only to the point of conducting a "design of an experimental concept" (pp. 26–27).

There is a serious controversy concerning home blood pressure monitoring kits. Manufacturers of higher-priced mercurial (using mercury level to measure) devices claim that this type of device is the only accurate way to measure blood pressure. On the other hand, distributors of inexpensive aneroid (using air pressure) devices argue that this type of device, while not as accurate as a mercurial device is certainly accurate enough for home use since it meets the federal accuracy standard of .3 millimeters. Thus, the aneroid distributors

argue that any difference in accuracy does not justify the higher cost of mercurial devices (p. 28).

An anomaly in wording of Section 1861(s) of Title XVIII of the Social Security Act has led to denials of coverage of oxygen tents and other durable medical equipment to patients in skilled nursing facilities and residents of intermediate care facilities while elderly people living outside these institutions do receive this coverage (pp. 28–29).

Contract Purchasing

Several existing government programs have demonstrated tha by making use of volume contract purchasing of eyeglasses, hearing aids, and dentures, the costs of these appliances are lowered by as much as 500 percent. The most extensive of these programs is operated by the Veterans Administration. In 1974, for example, the VA purchased 13,700 hearing aids from 14 companies and provided them to those eligible at a cost of $205 per hearing aid. This cost has been confirmed by a General Accounting Office report and is $145 below the average retail hearing aid cost. Programs operated by the Department of Defense, General Services Administration, and the State of Michigan are other examples of contract purchasing programs that have provided medical appliances for prices well below retail levels (pp. 30–33).

Recommendations to the Congress

1. Medicare Part B should be extended to cover eyeglasses, hearing aids, and dentures and related medical care (pp. 34–36)

Because of the great need of the elderly for eyeglasses, hearing aids, and dentures, and because of the hardship that paying for these expensive appliances represents to them, the subcommittee considers it essential that federal assistance be increased to meet those needs. This should be done either as part of a comprehensive national health insurance program or separately, as an extension of the Medicare program (p. 34).

The subcommittee believes that in the absence of national health insurance it is vital that the optional Part B section of Medicare be extended to cover the cost of hearing aids, eyeglasses, dentures, and medical care related to fitting those items. With the extension, elderly people who chose to enroll in the voluntary Part B program, would be covered for 80 percent of the reasonable charges for these health expenses once they had spent more than $60 in that year on covered Part B medical care expenses (p. 35).

To pay for the additional benefits, Part B monthly premiums and the federal contribution to the Medicare program would be increased slightly. That increase would be in accordance with the apportionment system used in 1977 to divide total Part B costs between the federal government and the elderly paying the premiums. Thus, the effect of the proposal would be an increase of $2.66 a month in premiums and an increase of $1.9 billion in the federal share of the program during the first year of the Medicare extension. As is presently done with the federal share of the existing Medicare Part B program,

all the federal funds would be paid from general revenues in order to protect the integrity of the Social Security Trust Fund. In addition, it is important to note that the cost of the federal share and of the premiums would decline by as much as one billion dollars a year after the fifth year of the program since the enormous *backlog* of elderly people who desperately need medical appliances will be reduced by that time (p. 35).

The subcommittee has found that the Medicare Part B extension could be quickly implemented by making use of the existing Medicare administrative mechanisms. The additional coverage would represent no extra burden to these mechanisms (p. 35).

In addition, Medicare should be extended to cover oxygen tents for all elderly people, rather than just those outside of skilled nursing facilities or intermediate care facilities (p. 36).

2. Medicare should utilize contract purchasing where feasible in providing eyeglasses, hearing aids, and dentures to the elderly (pp. 36–38)

While it is imperative that Medicare benefits be extended, it is equally imperative that the extension not be done in such a way as to allow the inadequacies and abuses of the present delivery system of medical appliances to continue. The subcommittee thus recommends that volume contract purchasing of eyeglasses, hearing aids, and dentures be utilized by the Department of Health, Education, and Welfare to provide these appliances to those elderly people who opt to receive the Part B coverage. HEW should begin to experiment with contract purchasing immediately. Within 5 to 10 years, it should be the official HEW policy that contract purchasing be utilized wherever feasible in the purchase of eyeglasses, hearing aids, and dentures for those covered. The subcommittee also recommends that states consider making use of contract purchasing of medical appliances as part of their Medicaid programs. Existing government contract purchasing programs are conclusive proof that this recommendation would result in a reduction in the actual cost of medical appliances from the excessively high levels of the present (pp. 36–37).

Under contract purchasing, manufacturers of medical appliances would submit bids to the Department of Health, Education, and Welfare. HEW would on the basis of competitive bidding, award contracts to selected manufacturers. The manufacturers would then distribute the agreed on devices to retail outlets. The retailers would provide the health aids to those elderly people who have paid the Part B premiums and would receive reimbursement from Medicare (p. 37).

Recommendations to Federal Departments, to the States, and to Consumers

1. A series of safeguards should be implemented to end abuses against medical appliance consumers (pp. 38–41)

Because of evidence of abuses and inadequacies in the present pricing and delivery systems of medical appliances, it is urgent that a series of major safeguards be enacted to protect elderly consumers from the kinds of abuses that they suffer today. Thus, the subcommittee recommends that the following safeguards be implemented by federal and state agencies (p. 38):

The first of these necessary safeguards is continued and increased scrutiny by the Federal Trade Commission and the Food and Drug Administration. For example, the subcommittee calls for an investigation by the Federal Trade Commission of unreasonable charges in the hearing aid, eyeglass, denture, and pacemaker industries (p. 38).

The second necessary safeguard is action by the states individually and the Federal Trade Commission nationally to remove the bans which bar price advertisements of medical appliances. According to the FTC's Bureau of Consumer Protection, these bans "reduce competition, restrict consumer access to information, and allow higher than competitive prices to exist" (pp. 38–39).

The third safeguard is improved HEW actions to reduce those Medicare expenditures which are excessive and unnecessary. First of all, HEW should immediately implement leasing and other economical methods of obtaining medical equipment. Legislation authorizing this was passed four years ago. The subcommittee can see no reason for the delay. Second of all, HEW should limit its payments for such devices as pacemakers to "reasonable charges" and stop paying for these devices when they are overpriced. Other HEW actions that are needed to end abuses of Medicare covered medical appliances include audits, on at least a random basis, of medical appliance manufacturers and providers and the imposition of a uniform system of quick and severe penalties for those manufacturers, providers and consumers who defraud the public or Medicare in this area. Regulations are also needed to protect the freedom of choice of Medicare recipients in purchasing durable medical equipment. Finally, HEW requirements are needed which would mandate cross referencing of "prevailing rates" (listing of prices by dealers in a given area) by all Medicare intermediaries (pp. 39–40).

Fourth, there is a particularly severe need for additional safeguards specifically directed at ending the inadequacies and overpricing of the present hearing aid delivery system. These include Federal Trade Commission regulations that would guarantee that hearing aid purchasers have the right to return hearing aids, end misrepresentation in hearing aid advertising, and would bar high-pressure techniques in the sale of hearing aids. In order to eliminate the widespread sale of unnecessary hearing aids, the subcommittee believes that the Food and Drug Administration should implement regulations which would require that everyone, except those allowed specific exemptions, be examined by a physician, preferably a hearing specialist before purchasing a hearing aid. In other words, a physician rather than a hearing aid dealer should determine if a person needs a hearing aid or not. The subcommittee thus believes that the regulation that has been proposed by the FDA which would require only persons under the age of 18 to have the examination, is not adequate. Finally, the subcommittee believes that increased HEW assistance to encourage continuing education and training programs for hearing specialists, clinical audiologists, and physicians is needed in order to improve the quality of the hearing care they provide. Similarly, state and local public health departments should be encouraged to provide greater hearing care to the elderly including a network of examination and treatment sites (pp. 40–41).

2. *All people purchasing eyeglasses, hearing aids, and dentures should use consumer discretion to avoid abuses such as overpricing and unnecessary services (pp. 41–43)*

The subcommittee recommends that all people purchasing medical appliances utilize consumer discretion to avoid overpricing and unnecessary services so that they will have eyeglasses, hearing aids, and dentures of the highest possible quality and the lowest possible price. The subcommittee has listed suggestions at the conclusion of the report. In addition, where appropriate, the federal government and the regional and local authorities should disseminate such information (pp. 41–43).

MEDICAL APPLIANCES AND THE ELDERLY: UNMET NEEDS AND EXCESSIVE COSTS FOR EYEGLASSES, HEARING AIDS, DENTURES, AND OTHER DEVICES

INTRODUCTION

The well-being of millions of older Americans is dependent on their use of one or more medical appliances. Indeed, medical appliances are so important to these elderly Americans that it would be impossible for them to have meaningful lives of the quality that they have become accustomed to and that they deserve without them. For example, for many elderly people without necessary hearing aids, hearing loss becomes a frustrating disability which interferes with vocational activities and social interactions, thus, increasing the severe emotional and social isolation that is associated with old age. Similarly, without necessary dentures, older people lose their ability to chew and digest foods that they desperately need to meet nutritional requirements. Finally, without necessary eyeglasses, elderly people lose essential visual contact with the world around them and grow more and more isolated from family and friends. In short, *for millions of elderly Americans, medical appliances are essential to life itself.*

Because of the crucial importance of medical appliances, the Subcommittee on Health and Long-Term Care believes that the needs of the elderly for these health aids must be met. *Presently, those needs for medical appliances are not being met.*

The subcommittee has found that millions of elderly Americans need medical appliances like hearing aids, eyeglasses, and dentures but do not have them because, in many cases, they cannot afford the high costs of these health aids. These costs are an enormous burden for all older Americans because they have, on the average less than half of the income of their younger counterparts. It is a particularly difficult burden for the one-third of the elderly bordering on or below the poverty level. As Nelson Cruikshank, President of the National Council of Senior Citizens, has pointed out, if elderly people cannot afford the medical appliances that they must have:

> They pay but not in dollars. They pay in the quality of life. Some cut down on food requirements. Some go without the proper type of shelter. Some cut off their social life. Many just do without (eyeglasses, hearing aids, and dentures) and fall back into more and more seclusion and live a restricted life because these appliances are not available to them as they should be.

Despite the fact that large numbers of elderly people cannot afford the medical appliances that they so desperately need, *neither public nor private health benefit programs have been sufficiently helpful to the elderly in this area.* Medicare, for example, provides no coverage of necessary medical appliances. As the chart on page 2 indicates, Medicaid does cover some devices, but only for the poor of a small number of states and thus, it pays for only a small fraction of these costs. Finally, private health insurance policies rarely provide coverage of medical appliances. The result of all this is that the elderly paid almost all of the $1.2 billion that was spent for medical appliances for the aged in 1975 out of their own pockets. When they are unable to afford to do so, in the words of Dr. Sidney Wolfe, Director of Public

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Citizen's Health Research group, the only way out is to make impossible choices. It is impossible for a senior citizen to decide whether or not they want to hear what goes on in the world or whether they want to eat.

The choices which senior citizens are forced to make about medical appliances due to the inadequacy of health benefit programs are yet more "impossible" because of the financial burden that the elderly bear in other health areas. The cost that the elderly must pay for all types of health care, not just medical appliances, continues to skyrocket. The average out-of-pocket cost paid by the elderly for health care has increased from $178 in 1966 to $415 in 1974. This increase has occurred despite the Medicare program, which now pays a lower percentage (38 percent) of the medical bills of the elderly than when it began (46 percent).

SELECTED MEDICAID SERVICES, STATE-BY-STATE

Totals	Hearing aids	Dentures	Eyeglasses	Durable medical equipment
Alabama	Not provided	Not provided	Provided with limits	Provided with limits.
Alaska	do	do	do	Do.
Arizona [1]				
Arkansas	Not provided	Provided with limits	Provided with limits	Do.
California	Provided	do	do	Do.
Colorado	Not provided	Not provided	do	Do.
Connecticut	Provided	Provided with limits	do	Do.
Delaware	Not provided	Not provided	do	Not provided.
District of Columbia	do	Provided with limits	do	Provided with limits.
Florida	do	Not provided	Not provided	Not provided.
Georgia	do	Provided with limits	Provided with limits	Provided with limits.
Guam	Provided			
Hawaii	Not provided	Provided with limits	Provided with limits	Do.
Idaho	do	Not provided	Not provided	Do.
Illinois	Provided	Provided with limits	Provided with limits	Do.
Indiana	do	do	do	Do.
Iowa	do	do	do	Do.
Kansas	do	Provided no limits	do	Do.
Kentucky	Not provided	Not provided	do	Do.
Louisiana	Provided	do	do	Do.
Maine	Not provided	Provided with limits	do	Do.
Maryland	do	do	do	Do.
Massachusetts	Provided	do	do	Do.
Michigan	Not provided	do	do	Do.
Minnesota	Provided	do	do	Provided no limits.
Mississippi	Not provided	Not provided	do	Not provided.
Missouri	do	Provided with limits	do	Do.
Montana	Provided	do	do	Provided with limits.
Nebraska	do	do	do	Do.
Nevada	do	do	do	Do.
New Hampshire	do	Not provided	do	Do.
New Jersey	Not provided	Provided with limits	do	Do.
New Mexico	Provided	do	do	Do.
New York	do	do	do	Do.
North Carolina	Not provided	do	do	Do.
North Dakota	Provided	Provided no limits	Provided no limits	Provided no limits.
Ohio	do	Provided with limits	Provided with limits	Provided with limits.
Oklahoma	Not provided	Not provided	do	Do.
Oregon	Provided	Provided	Provided	Provided.
Pennsylvania	Not provided	Provided with limits	Provided with limits	Provided with limits.
Puerto Rico	do	Not provided	Not provided	Not provided.
Rhode Island	Provided	Provided with limits	Provided with limits	Provided with limits.
South Carolina	Not provided	Not provided	do	Do.
South Dakota	do	do	do	Do.
Tennessee	do	Provided with limits	do	Do.
Texas	do	do	do	Do.
Utah	Provided	do	do	Do.
Vermont	do	Not provided	Not provided	Provided no limits.
Virgin Islands	do	Provided with limits	Provided with limits	Provided with limits.
Virginia	do	Not provided	do	Do.
Washington	do	Provided with limits	do	Not provided.
West Virginia	do	do	do	Provided with limits.
Wisconsin	do	Provided no limits	Provided no limits	Provided no limits.
Wyoming	Not provided	Provided with limits	Provided with limits	Provided with limits.

[1] Not applicable.

To make this situation yet worse, *the elderly who are able to afford needed medical applicances are frequently the victims of abuses such as overpricing and unnecessary services.* In the hearing aid industry, for example, there is conclusive evidence of misrepresentation, restraint of trade, price fixing, inadequate training of dealers, and ineffective licensing laws. Throughout the medical appliance area, the lack of standardization makes it difficult for older persons to make price comparisons between products. Also, the elderly often rely heavily on the advice of the medical equipment supplier in the selection of a particular item and the supplier may have little training and a strong interest in maximizing profits.

Thus, there are two key inadequacies in the present delivery system of medical appliances to the elderly; high prices which keep people who need the devices from having them and widespread abuses against those who do purchase the devices. Clearly the time has come for increased federal assistance in this crucial area. This nation cannot continue to ignore the need of the elderly for high quality medical appliances at prices that they can afford. The people of this country cannot sit idly by as the cost of health care that is paid by the elderly continues to reach higher and higher levels. In short, the time has come for this nation to move ahead and provide more of the essentials of life to the elderly.

The subcommittee believes that extending the optional Part B section of Medicare so that it would cover the cost of hearing aids, eyeglasses, and dentures is imperative in attempting to solve the problems of the high costs paid by the elderly for health care in general and medical appliances in particular. Yet the subcommittee emphasizes that any such increase in federal assistance represents only part of the solution. While it is necessary that Medicare benefits be extended, it is equally imperative that any extension of benefits that is made not be done in such a way as to allow the inadequacies and abuses of today's delivery system of medical appliances to continue.

For this reason, it is essential that two major reforms accompany the extension. First of all, *the government should utilize large volume contract purchasing of eyeglasses, hearing aids, and dentures, as the Veterans Administration and other agencies now do, thus reducing the cost of medical appliances from the excessively high levels of the present.* Second of all, *a series of major safeguards are needed to protect the elderly consumers from the kinds of abuses that presently dominate the market.* The subcommittee, based on its investigation of the needs and costs of medical appliances, believes that the extension of Part B of Medicare so that it would cover hearing aids, dentures, and eyeglasses, the use of contract purchasing, and the institution of safeguards are all desperately needed by the elderly. The subcommittee therefore believes that legislation to accomplish these ends should be enacted by the Congress.

Finally, in considering these issues, the subcommittee believes that it is especially important that the American people and the American Congress bear in mind one crucial idea; *the most important level on which these problems and recommendations can be considered is the human level.* This report should be viewed as a discussion of the crucial needs of *people* and not a collection of statistics with no meaning. In human terms, the high cost of medical appliances and

the widespread abuses mean that many of our 22 million elderly people, who have contributed more to the nation than any other segment of the population, are now suffering tremendous hardships. As the following remark by Doctor Robert Lytle of the American Dental Association demonstrates, when these hardships are looked at on a human level, it becomes clear that we must do all that we can to answer the needs of the elderly and to end the abuses that they now suffer in this area.

If we are lucky, we will all grow old. But how frightening to grow old and not be able to see clearly, hear distinctly, or eat properly because we cannot afford the necessary medical appliances to aid our failing facilities.

CHAPTER I—VISION CARE

A. NEED FOR EYEGLASSES

Vision care represents the most glaring example of both the great need of our nation's elderly for medical appliances and the inadequacy of the existing pricing and delivery systems at meeting that need. The size of that need becomes evident with an examination of the following statistics: First of all, older Americans suffer from chronic vision impairments more frequently than from any other ailment except arthritis. Second of all, since vision deteriorates with age, there are more cases of eye problems among the elderly than any other segment of the population. At the present time, over 20 million Americans over 65, or 92% of our nation's elderly require and own eyeglasses or contact lenses.[1] Over 5 million of these people need new corrective lenses because the ones that they now have either do not help their sight or actually harm it. Countless additional elderly Americans need eyeglasses but do not have them. This vast need for proper glasses is especially critical because many eye diseases, such as glaucoma and senile cataracts, can lead to blindness if they are not detected and treated promptly. Since the rate of blindness among Americans over 65 is over eight and one half times as great as the number in the under 65 population, it can be concluded that these crucial vision needs of the elderly are largely ignored.

According to the National Center for Health Statistics, there are over 200 chronic vision impairments per 1,000 aged persons. Such conditions are most commonly reported in the South (whereas reported conditions ranged from 181.4 per 1,000 persons to 187.5 persons for the remainder of the country the reported prevalance in the South was 249.5), among the elderly in nonmetropolitan areas, and among the poorest old people.

Both distance and near vision require correction as they deteriorate with age. Regarding distance vision, while only 19.6 percent of the total population have 20/70 uncorrected vision or worse, 51.8 percent of people 65–74 and 55.5 percent of persons 75–79 years of age have 20/70 uncorrected vision or worse. Similarly, where the vision is corrected with eyeglasses or contact lenses, the number of persons in the general population with 20/70 vision or worse is 3.2 percent, whereas for persons 65–74, the percentage is 10.1 and for persons aged 75–79, the figure is 19.1 percent.

For near vision the situation is worse. Over 35 percent of all persons have uncorrected vision of 14/49 or worse. For persons aged 65–74 the figure is 85.8 percent. For corrected near vision, 6.3 percent of the general population had near vision of 14/49 or worse. 14.4 percent of the 65–74 age group and 26.9 percent of the 75–79 age group had near vision of 14/49 or worse despite some corrective measures.

[1] Since less than one percent of all Americans over 65 wear contact lenses, this report will concentrate on eyeglasses in discussing vision care and corrective lenses.

According to the National Center for Health Statistics, *five million elderly people are wearing glasses which need correction.* In many cases, elderly people have glasses which are so inadequate that they not only do not help them; they may actually harm their vision. A survey of elderly people who wear glasses conducted by the National Center for Health Statistics provided documentation of this:

> Forty-four percent of the examinees were tested at distance with and without their glasses. This represents essentially all persons who stated they wore glasses for distance vision. Glasses improved acuity for 76 percent, while 19 precent tested the same with glasses as without, and five percent did better without glasses.
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> Over half of the examinees (52 percent) were tested both with and without glasses for near vision. (An additional four percent stated they wore glasses for near work but did not bring them to the examining center.) Of those tested with glasses or contact lenses, 83 percent had improved acuities with correction, 14 percent were unchanged, and three percent did less with than without their glasses.

Finally, while no data is available, the subcommittee believes that in addition to the five million people who have inadequate glasses, countless more elderly people need glasses, but simply cannot afford to purchase them.

In many cases, the consequence of not having proper glasses is that elderly people are mistakenly believed to be senile when in actuality they are simply unable to see necessary stimuli. A study by the Ebenezer Society, a leading Geriatrics Center in Minneapolis, Minn., has confirmed that in many cases, older persons may "have been inappropriately labeled mentally impaired as a result of unresolved vision needs."

B. THE PRESENT DELIVERY SYSTEM OF GLASSES AND ITS ABUSES

The subcommittee has found serious evidence of abuse of the rights and trust of consumers in the present delivery system of eyeglasses in a New York Department of Consumer Affairs survey. The study indicates that *one out of five eye examinations given to their own investigators (posing as typical consumers) by optometrists resulted in unnecessary prescriptions for eyeglasses.* In addition to raising questions about the ethics of some of the surveyed optometrists, the large number of unnecessary prescriptions demonstrates the need for minimum requirements for examinations. The latter conclusion is based on the fact that, in the survey, the optometrists who performed the least adequate tests generally were the ones who gave the incorrect prescriptions.

In the study, eight Department of Consumer Affairs (DCA) staff investigators who did not need new glasses went to optometric establishments selected at random throughout New York. The investigators requested routine vision exams and did not complain of any symptoms. Needless to say, the investigators answered any questions that they were asked during the examinations truthfully. If the optometrists said that they needed eyeglasses, the investigators purchased them. The glasses were then examined by two DCA consultants who compared the investigator's vision with the prescribed lenses. They found that "erroneous prescriptions for unneeded eyeglasses were given by 11 of the 16 surveyed optometric establishments in 22 out of a total of 111 examinations." The following represents one example of the prescription of unneeded eyeglasses that occurred in the study:

One investigator in a sworn affidavit, stated that when he went to an optometrist he was told that he had 20–20 vision. The investigator stated that "after the optometrist shone a small flashlight into my eyes he informed me that my eyes were sensitive to light. He implied that this was an abnormal condition and told me that I needed dark glasses to correct this." The optometrist told him to select a pair of frames with the receptionist. When the investigator told the receptionist that he did not want to purchase the dark glasses, the receptionist responded that he had to purchase the glasses because the doctor said that he needed them and that he might as well purchase them now because he would need dark glasses sooner or later.

One reason why so many unnecessary prescriptions were made in the study was that many of the eye examinations were made under inadequate conditions. For example, in 17 of the examinations, the optometrists projected improperly focused eye charts, so that those tested were unable to see the chart clearly. In 21 other cases, the lighting in the testing room was too bright for the chart to be read correctly. In most cases, these inadequate tests were the basis for prescriptions for eyeglasses that were in fact unnecessary.

C. COST OF EYEGLASSES

Information received by the subcommittee, as well as a survey conducted by the subcommittee, have resulted in serious evidence of massive overpricing and enormous variance in the cost of eyeglasses. For example, the New York Consumer Service Society reported that "New Yorkers who purchased eyeglasses paid two and a half times (or 250 percent more) in one place as in another for the *same set* of commonly prescribed lenses in a standard frame." Virginia Long, the New Jersey Director of Consumer Affairs has charged that in her state there is a 300 percent variation in the cost of the same eyeglasses.

In order to confirm these reports, the subcommittee conducted a survey of randomly selected firms selling eyeglasses retail in the Washington area. The firms provided the following prices for their least expensive eyeglass frames and the least expensive plastic and glass lenses:

	Frames	Lens, glass, pair	Lens, plastic, pair	Col. 1 + col. 2	Col. 1 + col. 3
	(1)	(2)	(3)	(4)	(5)
Firm A	[1] $6.25	$15.00	$20.00	$21.25	$26.25
Firm B	22.50	27.50	27.50	50.00	50.00
Firm C	17.50	25.00	27.50	42.50	45.00
Firm D	8.95	14.95	19.95	23.90	28.90
Firm E	9.00	25.00	30.00	34.00	39.00

[1] The quoted figure was between $6 and $6.50. The average of the 2 figures was used.

This subcommittee survey demonstrates a 230 percent variance in the cost of identical eyeglasses with glass lenses and an almost 200 percent variance in the cost of the identical eyeglasses with plastic lenses.

The subcommittee believes, as does the New York Community Service Society, that "Price variations of this magnitude cannot be explained away by differences from firm to firm in merchandise quality, overhead and wholesale costs."

D. COVERAGE UNDER EXISTING HEALTH BENEFIT PROGRAMS

Medicare covers virtually no optometric services. The 1967 Social Security Amendments excluded coverage of "eyeglasses, eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, or any procedures performed (during the course of any eye examination) to determine the refractive state of the eyes."

Medicaid does provide coverage of the diagnosis and treatment of eye conditions. In addition, many states provide optometric services. For example, as of August 1, 1975, 15 states offered optometric services to people receiving federally supported financial assistance. Twenty-three more states, in addition to offering optometric services to these categorically needy people, also offered such services to the medically needy, people in public assistance and SSI categories who are financially eligible for medical but not for financial assistance.

A number of state Medicaid programs do provide eyeglasses to the needy. Eleven states offer eyeglasses to the categorically needy and 25 more states also offered eyeglasses to the medically needy.

The tragic aspect is that given their very limited financial resources, states have been forced to cut from the Medicaid program desperately needed optometric services and eyeglasses. Other states have not dropped these services but have limited their coverage of vision care by imposing such restrictions as requiring copayment and providing eyeglasses and optometric services only to children. Other restrictions have included a limit on the frequency of obtaining new prescriptions and eyeglasses and the amounts paid for eyeglasses, and the frequency of refractions and dispensing eyeglasses.

In Michigan and Georgia, for example, optical services are provided to children only. The Texas Medicaid program provides only one pair of eyeglasses for a 24 month period, with certain qualifications, and limits refractions to once every year. In Maryland, different limits are imposed for children and adults, with children allowed to obtain new prescriptions more frequently. Maryland allows no replacement for lost or broken glasses. According to the acting director of the state Medicaid program in Michigan, costs for eyeglasses are limited to the following amounts in that state; $35 for single vision glasses and $50 for bifocals and trifocals. In the District of Columbia, the Medicaid program pays the dispenser his wholesale price plus $10.50 as a dispensing fee. There is a dollar limit of $5 for plastic frames and $7 for plastic and metal frames. There is no limit on the price of lenses, which are purported to average about $12. The Texas Medicaid program uses a similar approach with some variations. Other states, such as Virginia, charge the patient $2 for a pair of eyeglasses, and $2 for any repair costing more than $5.

Health insurance policies are even less helpful to the elderly in need of vision care than Medicare and Medicaid are. Such policies rarely cover any vision care services, according to the testimony before the Subcommittee of the nation's leading health insurance companies.

CHAPTER II—DENTAL CARE

A. NEED FOR DENTURES

Dental problems such as tooth decay and periodontal disease are so widespread among the elderly that half of all persons over 65 years of age are edentulous (without any natural teeth). While a majority of these people do have the dentures that they require, the inadequacy of the present pricing and delivery system of dentures and of the health benefit programs intended to meet such problems is revealed in the fact that according to the National Center for Health Statistics, 6.2 percent have neither natural teeth nor dentures and 30 percent have dentures which are ineffective and which require refitting or replacement. Additional proof of this inadequacy is the fact that the elderly, the population segment which most needs dental care, receives less dental care than the rest of the population. Frequently, this is due to the elderly being unable to afford the cost of dental care. These dental care problems are very serious for two reasons. The first reason is that persons who are without dentures for too long a time after they have had their teeth removed, may never be able to wear dentures when they do get them. The second reason is that the lack of teeth or the use of faulty dentures frequently results in changes in food selection due to chewing difficulties, and these changes can cause nutritional deficiencies.

By the time persons in this country reach the 65 to 74 age group, an average of roughly 23 of their teeth are missing, decayed, or filled. The following table, which was compiled by the National Center for Health Statistics shows the number of decayed, missing or filled teeth among all adults in the United States.

MEAN NUMBER OF DECAYED, MISSING, AND FILLED TEETH AMONG DENTULOUS ADULTS, BY SEX AND AGE: UNITED STATES, 1960–62

Sex and age	Total DMF teeth	Decayed	Missing	Filled
BOTH SEXES				
Total, 18 to 79 years	17.9	1.4	9.4	7.0
MEN				
Total, 18 to 79 years	17.2	1.5	9.2	6.5
18 to 24 years	13.4	2.2	4.6	6.6
25 to 34 years	15.8	1.8	6.2	7.8
35 to 44 years	17.2	1.3	8.1	7.8
45 to 54 years	18.0	1.3	10.9	5.8
55 to 64 years	20.4	1.1	14.7	4.6
65 to 74 years	22.3	.8	18.1	3.5
75 to 79 years	24.4	.7	21.7	2.0
WOMEN				
Total, 18 to 79 years	18.5	1.4	9.6	7.5
18 to 24 years	14.1	2.0	5.0	7.2
25 to 34 years	17.5	1.6	7.5	8.4
35 to 44 years	18.8	1.3	9.2	8.3
45 to 54 years	19.6	1.1	11.5	7.0
55 to 64 years	21.9	.8	14.8	6.3
65 to 74 years	22.8	.5	16.8	5.5
75 to 79 years	25.0	.7	20.1	4.3

Note: Filled teeth include only teeth with satisfactory fillings. Decayed teeth include not only teeth with caries but also filled teeth with carious lesions or defective fillings. Missing teeth include both missing and nonfunctional teeth. DMF is the total of these 3 categories. 3d molars are included in the count.

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In addition to the problem of tooth decay, periodontal disease (a disease which affects the bone and tissue that support the teeth) is endemic among the aged. Like tooth decay, the prevalence of periodontal disease rises sharply with age, as can be seen from the following table which was compiled by the National Center for Health Statistics.

PERCENT DISTRIBUTION OF ADULTS, BY STATUS OF PERIODONTAL DISEASE ACCORDING TO SEX AND AGE UNITED STATES, 1960–62

Sex and age	Status of periodontal disease			
	Total	Without periodontal disease	With periodontal disease	
			Without pockets	With pockets
BOTH SEXES				
Total, 18 to 79 years	100.0	26.1	48.5	25.4
MEN				
Total, 18 to 79 years	100.0	20.9	49.0	30.1
18 to 24 years	100.0	29.0	60.6	10.3
25 to 34 years	100.0	26.3	51.7	22.0
35 to 44 years	100.0	22.1	48.1	29.7
45 to 54 years	100.0	15.0	48.1	36.9
55 to 64 years	100.0	15.3	39.1	45.6
65 to 74 years	100.0	5.6	36.0	58.4
75 to 79 years	100.0	6.2	33.7	60.0
WOMEN				
Total, 18 to 79 years	100.0	31.0	47.9	21.0
18 to 24 years	100.0	36.8	53.6	9.6
25 to 34 years	100.0	37.6	50.2	12.3
35 to 44 years	100.0	33.3	46.2	20.5
45 to 54 years	100.0	26.6	43.7	29.6
55 to 64 years	100.0	20.8	43.6	35.5
65 to 74 years	100.0	15.2	52.0	32.8
75 to 79 years	100.0	11.0	35.3	53.8

The National Center for Health Statistics attempted to measure the severity of periodontal disease, in addition to its prevalence. The following table demonstrates that the severity of periodontal disease (measured by the periodontal index) also increases with age.

AVERAGE PERIODONTAL INDEX OF WHITE AND NEGRO ADULTS, BY SEX AND AGE: UNITED STATES, 1960–62

Sex and age	All races	White	Negro
BOTH SEXES			
Total, 18 to 79 years	1.13	1.06	1.60
MEN			
Total, 18 to 79 Years	1.34	1.28	1.79
18 to 24 years	.62	.58	.78
25 to 34 years	.92	.87	1.30
35 to 44 years	1.27	1.22	1.67
45 to 54 years	1.62	1.55	2.06
55 to 64 years	2.15	2.00	3.13
65 to 74 years	2.50	2.47	2.83
75 to 79 years	2.91	3.01	2.16
WOMEN			
Total, 18 to 79 years	.93	.85	1.43
18 to 24 years	.48	.46	.62
25 to 34 years	.60	.53	.95
35 to 44 years	.82	.74	1.30
45 to 54 years	1.23	1.11	1.92
55 to 64 years	1.56	1.39	2.90
65 to 74 years	1.62	1.51	2.03
75 to 79 years	2.94	2.41	5.53

11,400,000 Americans over the age of 65 are edentulous as a result of tooth decay and periodontal disease. This figure represents 45.2 percent of persons 65 to 74 and 59.8 percent of people over 75. The reason for this high rate of edentulousness is that the senior citizens of the present grew up in a time before the benefits of flouridation and other preventive measures were known. In other words, the high rate of edentulousness of today's elderly exists because extraction of teeth, which today is a last resort in nearly every instance, was far more common in the past when alternate tooth-saving procedures were not known. Thus, many of the dental problems which are so very acute among today's elderly, will become less serious among the elderly of the future. For example, data published by the National Center for Health Statistics demonstrates a significant decline in the number of edentulous elderly Americans from 1958 to 1971. As the following table indicates, for those between 65 and 74 there was a decline of 10 percent, while for those over 75 the decline was 7.5 percent.

PERCENT OF EDENTULOUS PERSONS IN THE POPULATION, BY SEX AND AGE: UNITED STATES, JULY 1957–JUNE 1958 AND 1971

Sex and age	July 1957–June 1958	1971
BOTH SEXES		
All ages	13.0	11.2
Under 15 years		
15 to 24 years	.9	.3
25 to 34 years	3.6	3.6
35 to 44 years	9.6	9.3
45 to 54 years	22.4	17.3
55 to 64 years	38.1	30.8
65 to 74 years	55.4	45.2
75 years and over	67.3	59.8
MALE		
All ages	11.9	10.1
Under 15 years		
15 to 24 years	.9	.3
25 to 34 years	2.6	3.2
35 to 44 years	8.8	8.2
45 to 54 years	21.9	16.5
55 to 64 years	35.9	30.5
65 to 74 years	52.8	45.0
75 years and over	62.4	56.3
FEMALE		
All ages	14.1	12.2
Under 15 years		
15 to 24 years	.9	.3
25 to 34 years	4.5	4.0
35 to 44 years	10.3	10.4
45 to 54 years	22.8	17.9
55 to 64 years	40.1	31.1
65 to 74 years	57.6	45.4
75 years and over	71.0	62.2

Additional statistics from the American Dental Association demonstrate that this decline will continue. These figures show that the rate of edentulousness is steadily declining among the younger age groups that will make up the elderly of the future. For example, a 1960 survey indicated that 31 percent of those between the ages of 30 and 39 were already wearing dentures or bridges. A 1975 survey indicated that the figure has dropped to 11 percent.

Among the 11.4 million elderly Americans who are without natural teeth, the National Center for Health Statistics has reported some shocking statistics. First of all, 600,000 elderly Americans are without any teeth whatsoever; they have neither natural teeth nor dentures. Second of all, 350,000 edentulous people over 65 had dentures which were incomplete. In addition, the Department of Health, Education and Welfare has reported that almost one-third of the edentulous elderly, or 3.4 million people, have dentures which need to be replaced or refitted. With this in mind, it comes as no surprise to learn that 1.3 million people over 65 had so much difficulty wearing these inadequate dentures that they never used them or wore them only part of the time. The large number of persons in need of dental care because

they have dentures which are so inadequate that they have difficulty wearing them, points out a special problem of the aged. According to an article by Dr. Jay W. Friedman appearing in Geriatrics Magazine,

> The average denture patient has a sore mouth, dissatisfaction with his chewing capacity, and the fear that his teeth will come loose at embarrassing moments. Many elderly persons have given up chewing with their dentures and use them only for appearance in social situations. Although temporary stability may be obtained by use of denture adhesives, it is very short lived and denture wearers find these powders and pastes literally distasteful.

The seriousness of this problem should not be underestimated, for in addition to causing soreness, ill fitting dentures have even, in some instances, caused cancerous lesions, according to Dr. Friedman.

All of the above statistics have demonstrated that the elderly have severe dental care problems; problems which are the results of years of inadequate dental care and which are much more serious than those of the population as a whole. Thus, it is particularly shocking to discover that elderly people use considerably fewer dental services and see dentists 33 percent less frequently than other segments of the population as the following chart indicates:

PERCENT OF POPULATION WITH ONE OR MORE DENTAL VISITS WITHIN A YEAR OF INTERVIEW AND NUMBER OF DENTAL VISITS PER PERSON PER YEAR, BY AGE: UNITED STATES, JULY 1963–JUNE 1964 AND 1969

Characteristic (age)	Percent of population with dental visit within a year		Number of dental visits per person per year	
	July 1963–June 1964	1969	July 1963–June 1964	1969
All persons	42.0	45.0	1.6	1.5
Under 5 years	11.1	11.0	.3	.3
5 to 14 years	54.9	58.8	1.9	1.8
15 to 24 years	55.1	55.6	2.0	1.7
25 to 44 years	48.5	49.5	1.9	1.6
45 to 64 years	38.4	42.3	1.7	1.6
65 years and over	20.8	23.2	.8	1.0

The American Dental Association has provided information to the subcommittee which shows that 71.8 percent of the edentulous elderly population has not even visited a dentist within the past 5 years. While in some cases this statistic reflects the fact that these people do not require the care of a dentist, in many cases it is simply due to the fact that elderly Americans, frequently poor and on fixed incomes, have ignored their need for proper dental care because of their lack of money. That millions of poor elderly Americans are neglecting their dental care needs because of the high cost, is apparent from the following table, which illustrates the fact that persons over 65 with incomes of less than $3,000 visited the dentist only one fourth as often as elderly people with incomes in excess of $15,000.

One reason why it is extremely important that elderly Americans receive the dental care that they require is that persons who are without dentures for a long time after having their teeth removed are frequently unable to wear dentures when they finally do get them. In the 1950's, an experimental program was undertaken to provide dental care in the Kansas City metropolitan area for the chronically ill and aged. The program's dental staff found that persons who had been without dentures for 6 or more years could not be fitted for

dentures. Persons who had been without dentures for 5 or 6 years were considered borderline. Those fitted for dentures within 5 years after becoming edentulous could usually be fitted.

A second reason why it is extremely important that elderly Americans receive the dental care that they require is that the lack of teeth or the use of faulty dentures frequently means that an elderly person may be forced to choose foods that are easier to chew but lower in nutritional value. Edentulous people with faulty dentures or without any dentures tend to avoid foods like meats, raw vegetables, and fresh fruits because of the difficulty in chewing them. Yet, these foods are essential dietary ingredients for the elderly. For example, ascorbic acid (vitamin c) is particularly necessary to assure wound healing in the aged. However, because of chewing difficulty, it is not unusual for the elderly to have low intakes of the citrus fruits and fresh vegetables which are the natural sources of vitamin c. A study by the American Dental Association has confirmed the severity of this problem. The study showed that those people with the least chewing difficulty were able to consume the largest amounts of each of the nutritional elements. In short, edentulous people require high quality dentures in order to avoid dietary imbalance, borderline nutritional deficiencies, and even malnutrition.

B. THE PRESENT DELIVERY SYSTEM OF DENTURES

Because of the large number of dentists, eight out of ten Americans live in areas in which there is ready access to dental care services, according to the American Dental Association. Unlike the supply of physicians, the number of dentists per 100,000 people has remained virtually unchanged since 1960. Whereas the number of physicians per 100,000 increased from 136 per 100,000 in 1960 to 154 per 100,000 in 1970, the number of dentists increased from 49.4 to 49.6 per 100,000 during the same period. The Department of Health, Education and Welfare has projected an increase in dentists to 55.6 per 100,000 in 1980 as the following chart indicates. That increase would represent a 12 percent increase over 1970.

ANNUAL ADDITIONS AND LOSSES TO THE SUPPLY OF ACTIVE DENTISTS, USING BASIC METHODOLOGY: ACTUAL 1970 AND PROJECTED 1975 AND 1980

Year	Changes in supply Jan. 1–Dec. 31				Number active Dec. 31
	Jan. 1	Net gains	Graduate additions	Losses from deaths and retirements	
1970					102,220
1980	123,200	2,970	5,370	2,400	126,170

Source: BHRD, Division of Dental Health.

While the projected increase in the supply of dentists is relatively modest, the Department of Health, Education, and Welfare has projected far greater increases in the supply of allied dental workers. The following table shows the projected increases:

SUPPLY OF ACTIVE FORMALLY TRAINED SELECTED ALLIED DENTAL HEALTH PERSONNEL AND PERCENT CHANGE: 1970; PROJECTED 1980

[Basic educational preparation less than baccalaureate in level]

Occupation	Number of active formally trained personnel		Percent change 1970–80
	1970	1980	
Dental assistant	9,200	39,110	325.1
Dental hygienists	15,100	34,190	126.5
Dental laboratory technicians	1,600	7,070	341.9

As can be seen, it appears that allied dental workers are being substituted for additional dentists, because of the large number of dental services that can be delegated. Since 1967, the number of patients seen per dentist has increased by 12 percent. A 1970 study showed that a dentist working with one assistant could be 36 percent more productive than one working alone, and five assistants could make a dentist 236 percent more productive. To some extent, however, such increases in productivity are limited by State laws that specify the duties which can be delegated by dentists. Since 1970 states have been active in amending dental practice acts to allow dentists to delegate duties to dental auxiliaries. In a report prepared by the Division of Dentistry of the Health Resources Administration, it was noted that the number of states allowing the delegation of duties to dental auxiliaries increased from 24 to 44, or from 47 percent of the states to 86 percent. The extent of delegation allowed tends to vary with the states.

In addition to the dentist who takes the X-rays, makes the extractions and impressions, and works with the aged person to determine the best possible fit, there are a large number of persons and organizations who participate in supplying the elderly with dentures, including the manufacturers who produce the teeth and the supply houses who distribute the teeth and other materials to the laboratories.

C. COST OF DENTURES

The cost of dentures, like many other professional services for the elderly, varies widely. The cost, which includes the extraction of teeth, X-rays, the making of impressions, and the purchase of the dentures from the laboratory can vary from less than $500 to over $1,000 depending upon the dentist. However, the existence of a number of large clinics specializing in dentures which provide the exact same services for as little as one fifth of these costs, represents evidence of overpricing.

The Sexton Clinic in Florence, S.C., for example, provides dentures for substantially less than the average cost of $500 to $1,000. The following costs charged by the Sexton Clinic were provided by an employee of the clinic to the subcommittee.

1. Extractions—$3 per tooth (medication such as anticoagulants is additional).

2. Dentures—$50 (one style only which are made of acrylic).

Teeth are extracted and dentures fitted on the same day at the clinic. The procedure begins at three o'clock in the morning and is over at approximately seven o'clock the same evening. All work is done by appointment. Many of the persons using the clinic are elderly and travel from retirement areas such as Florida to take advantage

of the low cost of having their teeth extracted and new teeth put in at the Sexton Clinic. The clinic operates two motels for those people traveling long distances.

While the subcommittee has seen no basis for any such complaints, the South Carolina Dental Association, representing local private dentists, has been openly critical of the clinic and has alleged that they have received numerous complaints from patients of the clinic.

Additional evidence of overpricing of dentures is the fact that the actual cost of the teeth and other materials which go into the making of dentures, represents no more than *5 to 10 percent* of the cost paid by the patient for his or her dentures. In most cases, 75 percent of the final fee goes to the dentist for his services while the remainder goes to the laboratory which makes the dentures.

There has been a 284 percent increase in overall dental costs and a 225 percent increase in per capita costs since 1960, as the following table shows:

	1960	1965	1970	1975	Percentage change 1960–75
Dollars (millions)	$1,944	$2,728	$4,473	$7,500	284
Per capita	10.65	13.87	21.56	34.62	225

Dental costs have not increased as rapidly as overall national health expenditures or most other health costs have. For example, physicians' services costs have increased by 296 percent overall, and on a per capita basis by 234 percent. Overall hospital costs have increased by 448 percent, and per capita hospital costs by 362 percent. Americans spent roughly one third as much on dental services in 1975 as we did for physician services; $22.1 billion for physician services and $7.5 billion for dental services.

Mueller and Gibson, in an article appearing in the June 1975 Social Security Bulletin, reported on the cost of health services for the aged. The following table shows the cost of health services for the aged for the period from 1972 through 1974.

ESTIMATED DENTAL CARE EXPENDITURES FOR THE AGED, FISCAL YEARS 1972 TO 1974

	Total (in millions)	Per capita
Year:		
1972	$375	$17.90
1973	402	18.85
1974	429	19.58

Dental costs for the aged increased by roughly 14 percent, approximately the same as physician services, whereas overall costs of health care for the aged increased by roughly 23 percent.

As a percentage of total health care costs and expressed in absolute terms, the aged spend considerably less for dental care than does the remainder of the population. In 1975, the total population spent, or had spent on their behalf, nine percent of total national health expenditures on dental services. The aged spent, or had spent on their behalf 1.6 percent of total national health expenditures. This lower expenditure is not the result of less need, however; it is the result of the greater percentage of poverty among the elderly.

D. PAYMENT FOR DENTAL SERVICES UNDER MEDICAID, MEDICARE, AND OTHER HEALTH BENEFIT PROGRAMS

Dental services are optional under the requirements of the Medicaid program. Thus, the 4,232,550 aged people who are Medicaid eligible can receive dental care if they are lucky enough to live in a state which has opted to provide dental services under the Medicaid program. In December of 1974, 41 states offered some kind of dental care as part of their Medicaid programs. However, over the past 2 years, a number of state governments have cut back or eliminated many of their optional Medicaid services in order to reduce expenditures. The result of this is that by January 1976, only 36 states offered dental services as part of their Medicaid program (11 of those states covered dental services only to the categorically needy, while 25 states also provide coverage to the medically needy). This situation may continue to grow worse, leaving even more poor aged people without adequate dental care, as three more states (Ohio, Connecticut, and Illinois) are considering eliminating dental services from their Medicaid programs.

Medicare is even less helpful to the elderly in need of dentures but without the money to pay for them. Under Medicare, dental care is authorized only for surgery related to the jaw or any structure contiguous to the jaw or to reduce a fracture of the jaw or any other facial bone. Medicare provides no coverage for the routine dental services that are so badly needed by the elderly. Just how limited Medicare's coverage of dental services is can be seen from the fact that Medicare reported spending *no* money for dental care during 1975, according to the Mueller and Gibson study of health costs for the aged.

As for health insurance policies, the subcommittee has found that such policies are generally similar to Medicare in that they provide no coverage of routine dental services. In fact, dental costs are the least insured major health cost in the United States. It is estimated that roughly 10 percent of all Americans have dental insurance. Dental insurance, however, is the fastest growing line of health insurance. Between 1962 and 1974 dental insurance coverage increased by over 3,300 percent. The following table shows the numbers and percentage of the United States population covered by health insurance, including dental insurance.

ESTIMATES OF THE NET NUMBER OF DIFFERENT PERSONS UNDER PRIVATE HEALTH INSURANCE PLANS AND PERCENT OF POPULATION COVERED, BY SPECIFIED TYPE OF CARE, 1962–74

End of year	Hospital care	Physicians' services: Surgical services	Physicians' services: In-hospital visits	Physicians' services: X-ray and laboratory visits	Physicians' services: Office and home visits	Dental care	Prescribed drugs (out of hospital)	Private-duty nursing	Visiting-nurse service	Nursing-home care
	Number (in thousands)									
1962	120,800	120,528	(1)	65,671	(1)	1,006	47,907	46,143	43,203	4,975
1965	(1)	(1)	(1)	79,500	(1)	3,100	53,200	56,000	60,100	9,900
1966	(1)	(1)	(1)	90,000	(1)	4,227	65,544	68,722	79,004	17,814
1967	145,454	142,082	(1)	92,480	(1)	4,679	71,201	76,080	81,771	18,754
1968	(1)	(1)	128,174	97,703	(1)	5,821	79,280	83,485	90,523	19,046
1969	(1)	(1)	133,914	125,002	(1)	8,510	89,805	91,211	100,343	28,044
1970	154,263	150,001	145,589	142,441	101,970	12,210	100,966	100,235	106,882	32,392
1971	(1)	(1)	148,514	145,207	(1)	15,348	106,985	104,730	110,215	33,636
1972	155,253	152,651	149,734	149,444	(1)	17,904	111,374	108,959	115,904	45,400
1973	(1)	(1)	153,461	152,797	(1)	21,626	124,971	118,805	122,688	69,152
1974	163,393	159,518	155,022	153,017	125,183	33,297	141,755	141,167	136,687	69,840
	Percent of civilian population									
1962	70.0	65.0	(1)	35.0	(1)	0.5	26.0	25.0	23.0	3.0
1964	(1)	(1)	(1)	41.2	(1)	1.6	27.6	29.0	31.2	5.1
1966	(1)	(1)	(1)	48.0	(1)	2.2	33.7	35.0	40.6	9.2
1967	73.9	72.2	(1)	47.0	(1)	2.4	36.2	38.7	41.6	9.2
1968	(1)	(1)	64.5	49.2	(1)	2.9	39.9	42.0	45.5	9.6
1969	(1)	(1)	66.6	62.2	(1)	4.2	44.7	45.4	49.9	14.0
1970	75.9	73.9	71.7	70.2	50.2	6.0	49.7	49.4	52.6	16.0
1971	(1)	(1)	72.3	70.7	(1)	7.5	52.1	51.0	53.6	18.8
1972	74.9	73.8	72.2	72.1	(1)	8.6	53.7	52.6	55.9	21.9
1973	(1)	(1)	73.4	73.1	(1)	10.4	59.8	56.9	58.7	33.1
1974	77.6	75.7	73.6	72.7	59.4	15.8	67.3	67.0	64.9	33.2

[1] Data not available.

Payment for dental services through public programs has also increased rapidly. The following table shows the growth in public and private payments for dental services.

	Total (in millions)	Percentage distribution by source of funds: Private	Public
Fiscal year:			
1950	$940	100.0	----------
1955	1,457	100.0	----------
1960	1,944	99.8	0.2
1965	2,728	98.8	1.2
1970	4,473	95.3	4.7
1971	4,908	95.0	5.0
1972	5,342	94.8	5.2
1973	5,767	94.6	5.4
1974	6,200	94.5	5.5

In 1975, the cost of dental services was less than one percent of total public health program costs. The following table shows the increases in dental costs for public programs for the period from 1973 to 1975.

DENTAL COSTS UNDER PUBLIC PROGRAMS

[In millions]

	1973	1974	1975
Total	$321.4	$332.8	$414.8
Title IX	220.4	258.4	337.1
Veterans' Administration	55.2	44.9	51.4
Other	45.8	29.5	26.3
Federal	217.7	215.3	254.8
Title IX	119.6	144.7	180.7
Veterans' Administration	55.2	44.9	51.4
Other	42.9	25.7	22.7
State	103.8	117.5	160.1
Title IX	100.9	113.7	156.5
Other	2.9	3.8	3.6

For 1974, the last year for which data for both private dental health insurance and public programs is available, dental costs met by third party coverage was roughly $1.2 billion.

CHAPTER III—HEARING CARE

A. NEED FOR HEARING AIDS

Over *one half* of all persons 65 years of age and over suffer from impaired hearing according to the Federal Council on the Aging and the American Speech and Hearing Association. For 8 percent of the elderly, the hearing impairment is so serious that they are unable to hear words that are spoken in a normal voice. For millions of elderly Americans, the solution to these problems is the use of a suitable hearing aid. Yet, in attempting to purchase needed hearing aids, the elderly must confront inadequate regulation of hearing aid sales, excessively high prices, and a virtual lack of coverage under Medicaid, Medicare, and other health benefit programs.

Hearing impairment takes a variety of forms. The first form it can take is an inability to hear speech and other sounds loudly enough. This is referred to as a loss in hearing sensitivity or simply a hearing loss. A second form of hearing impairment is an inability to hear speech and other sounds clearly even though the sounds are sufficiently loud. What is heard may be similar to garbled speech from a radio with a broken speaker. This is referred to as an impairment in speech discrimination.

Many hearing impairments are subtle in nature and difficult to recognize. A mild hearing loss or a loss in hearing sensitivity for high frequency sounds may not be noticeable except under adverse listening conditions such as when the background is noisy or when the sound source is some distance away. A high frequency hearing loss may make it difficult for a person to differentiate between words that are the same except for differences in high frequency consonant sounds like f, s, or th. These sounds are often unheard or heard in a distorted way by people with high frequency hearing losses. Thus, words like fit and sit, or math and mass, are frequently confused.

The results of the most recent (1971) National Health Survey on hearing impairments indicate that there are 13.2 million people over 3 years of age and living outside of institutions, who had a hearing impairment of some kind in one or both ears. Of these, 6.2 million had good hearing in one ear and could usually function as well as people with normal hearing. About 60 percent of those with bilateral hearing problems reported that while they had some difficulty hearing, they could usually hear words spoken in a normal voice. However, the survey demonstrated that the remaining 2.4 million Americans had much more serious hearing impairments and were usually unable to hear words spoken in a normal voice.

The likelihood of having a hearing impairment rises sharply with increased age. The percentage of the population with hearing problems in one or both ears is shown in the following table.

Age	Percent of age group	Number (thousands)
3 to 16 years	1.62	905
12 to 24 years	2.65	723
25 to 44 years	4.47	2,118
45 to 64 years	10.00	4,178
All ages	6.90	13,228

Of the 5.3 million elderly people who had a hearing impairment, 3.3 million (17.3 percent of the aged) had a problem with both ears. The most serious problem is that *1.5 million elderly Americans (7.9 percent of the aged) were simply unable to hear words that were spoken in a normal voice*, as the following table indicates.

TABLE 1.—NUMBER OF PERSONS AND NUMBER OF PERSONS PER 1,000 POPULATION FOR PERSONS 3 YR OF AGE AND OVER WHO REPORTED HEARING PROBLEMS WITH ONSET OF HEARING LOSS AT ANY AGE, BY SPEECH COMPREHENSION GROUP, SEX, AND AGE: UNITED STATES, 1971

[Data are based on household interviews of the civilian, noninstitutionalized population]

Sex and age	All persons who reported hearing problems	Persons with bilateral hearing problems				Persons with problems in only one ear	Persons who reported to response to self-rating scale	Persons who did not respond to self-rating scale
		Total [1]	At best can hear words shouted in ear	Can hear words shouted across a room	Can hear words spoken in a normal voice			
All ages 3 years and over	13,228	6,414	707	1,740	3,878	6,225	336	253
3 to 16 years	905	394	37	114	240	423	61	[2] 27
17 to 24 years	723	214	[2] 13	49	148	462	[2] 33	[2] 15
25 to 44 years	2,118	615	46	109	452	1,377	66	60
45 to 64 years	4,178	1,845	135	421	1,262	2,166	88	79
65 years and over	5,304	3,347	475	1,048	1,777	1,798	88	72

[1] Includes 89,000 persons who did not respond to Gallaudet Scale.
[2] Indicates estimate has a relative standard error of more than 30 percent. In general, the relative standard error will be less than 30 percent when the population estimate is greater than 35,000.

Source: National Center for Health Statistics: Persons with Impaired Hearing, United States, 1971. National Survey, Series 10, No. 101.

According to the National Health Survey, slightly over a million aged people with hearing impairments were using hearing aids. For example, many elderly people with sensorineural hearing losses (a type of hearing impairment related to the nerves) were helped by the sound amplification of a hearing aid. According to Dr. Blue Carstenson of Carstenson and Associates, in many cases, the use of hearing aids ends the "isolation, degradation, and loneliness" of many older people who might otherwise be mistakenly "thought to be practically senile."

On the other hand in some cases such as profound hearing loss, a person cannot hear speech clearly even with the use of a hearing aid and may receive only limited benefit or no benefit from the use of one. In these cases, medical treatment, such as surgery, is necessary to correct the hearing loss.

B. THE PRESENT DELIVERY AND PRICING SYSTEM OF HEARING AIDS AND ITS ABUSES

Because of a great deal of public alarm, the delivery system and pricing of hearing aids has been the subject of numerous investigations. In October 1973, the Retired Professional Action Group (RPAG), a

nonprofit consumer advocacy group, undertook a detailed study of the hearing aid delivery system and published its findings in a report entitled "Paying Through the Ear: A Report on Hearing Health Care Problems." At approximately the same time this report appeared, the Subcommittee on Consumer Interests of the Elderly of the Senate Special Committee on Aging held hearings on "Hearing Aids and Older Americans." In May 1974, an Intradepartmental Task Force was established within HEW to examine the issues described in the RPAG report and the Senate Hearings. The Task Force report, entitled "Final Report to the Secretary on Hearing Aid Health Care," was published in July of 1975. In October 1975, a report was published by the staff of the Permanent Subcommittee on Investigations of the Senate Committee on Government Operations. The conclusion of these studies and of the investigation of the Subcommittee on Health and Long-Term Care is that there are several serious abuses which demand correction in the way that hearing aids are sold.

One of the most crucial issues that has been brought out of these investigations is that, as it is presently constructed, the hearing aid delivery system in the United States fosters a clear and continuing *conflict of interest* that pits the financial interests of the seller against the health and economic interests of the buyer. That is, at the present time, the profit orientation of the hearing aid dealer may cause him to sell a hearing aid to a person who has not been examined by a doctor and who might not need the expensive device. For example, a survey of hearing aid dealers in the District of Columbia that was made by the National Council of Senior Citizens showed that 27 percent of the dealers recommended the purchase of unnecessary hearing aids.

The subcommittee strongly favors, as a solution to the problem of the sale of unnecessary aids, a requirement that a person purchasing a hearing aid must first acquire a medical clearance from a physician, preferably a hearing specialist.

On April 21, 1976, the Food and Drug Administration proposed regulations, that would, in general, prohibit the sale of a hearing aid to a patient before he has been examined by a physician. Patients who are age 18 or older would be permitted to waive the medical examination if the seller determines that none of the following otological symptoms of a medical malfunction are evident at the time of the sale:

1. Visible congenital or traumatic deformity of the ear.
2. History of active drainage from the ear within the previous 90 days.
3. History of sudden or rapidly progressive hearing loss within the previous 90 days.
4. Acute or chronic dizziness.
5. Unilateral hearing loss of sudden or recent onset within the previous 90 days.
6. Audiometric air-bone gap equal to or greater than 15 dB (ANSI) at 500 Hz, 1000 Hz, and 2000 Hz.
7. Visible evidence of cerumen accumulation or a foreign body in the ear canal.

A 60-day period was provided for comments on the proposed regulation. At the present time, the Food and Drug Administration is analyzing those comments before issuing the regulations.

The subcommittee believes as does the American Speech and Hearing Association (ASHA) and others that the waiver loophole in the proposal represents a "double standard" in requiring an examination by a physician for hearing aid purchasers who are under 18, while permitting older people to waive the examination in most cases. Those who support the waiver argue that it is unnecessary because of such factors as the inconvenience of securing medical assistance in rural locations and religious beliefs which preclude consultation with a physician.

The subcommittee rejects this approach of using a waiver. It favors an alternative approach of granting exemption to those people who deserve them and requiring everyone else, regardless of age to receive a medical examination before purchasing the hearing aid (see pp. 40–41).

The various investigations of the hearing aid industry have brought out other serious issues in addition to the need for a medical clearance requirement. One such issue is the need for adequate training of hearing aid dealers. Top quality instruction is essential because a dealer can only be competent if he or she has received such training. At the present time, the National Hearing Aid Society (NHAS) is the only organization offering a national instruction program for dealers. Most of the licensed hearing aid salesmen in the United States have taken this course of instruction which consists of 20 home study lessons. Yet, a 1975 review of this course by representatives of the Veterans Administration (which has provided hearing aids to veterans for 30 years), the American Council of Otolaryngology, and the American Speech and Hearing Association has severely criticized the NHAS home study course. The representatives of the Veterans Administration *concluded that the course was "not only inadequate but potentially dangerous"*. The VA continued, saying that,

> It is dangerous in the same way that "quack" medicine is dangerous * * * It postpones or prevents adequate evaluation, diagnosis, and treatment of hearing loss and its accompanying pathology. Some of those pathological entities are life-threatening and require immediate and aggressive medical or surgical treatment.

Similarly, the representatives of the American Council of Otolaryngology concluded that,

> * * * the Basic Home Study Course of the National Hearing Aid Society * * * is far too technical and beyond the scope of the simple salesman to comprehend in any effective manner. Most of the material has been written for professionals with college and post-graduate education.

Finally, the American Speech and Hearing Association, the national audiologists' group, concluded that,

> * * * a hearing aid dealer would not be competent, as a result of completing this course, to accurately evaluate hearing. Because of its extremely superficial nature and because it approaches the subject in a purely descriptive rather than interpretative manner, the hearing aid dealer who completes the course would still be ill-prepared to make the kinds of objective professional judgments and recommendations necessary for the satisfactory and ethical rehabilitation of patients with hearing impairments.

One solution that is under consideration to the severe inadequacy of the education received by most hearing aid dealers would be strong state licensure requirements to insure that hearing aid dealers meet a set of minimum qualifications.

Eleven states now have no such laws at all. In the other 39 states, the laws that have been enacted are frequently of only limited effective-

ness. The best example of this is the fact that nearly 50 percent of the licensed hearing aid dealers in the United States have never taken any kind of licensing exam. Instead, they have been "grandfathered" into licenses because they had been dealers prior to the enactment of these laws. Even more serious, is the conclusion of the staff of the Permanent Subcommittee on Government Operations that, "For the most part, control of the licensing boards rests in the hands of the dealers. In effect they regulate themselves."

In view of the virtual lack of oversight and scrutiny of the hearing aid industry, it is no surprise to learn that the Federal Trade Commission, the Food and Drug Administration, and numerous Congressmen and Senators have reported receiving hundreds of complaints of abuses in the industry. There have been numerous charges of false advertising and misleading promotional practices associated with the sale of hearing aids. In addition, there are numerous reports of high pressure door-to-door sales, misrepresentation of the expected benefits of wearing a hearing aid, and misleading statements about "technological innovations." As the report by the Permanent Subcommittee on Investigations stated,

> Many dealers who were complained against appeared to lack a strong sense of ethics or a degree of competence sufficient to evaluate the cause of hearing loss, to provide the proper hearing aid if one was indicated, or to refer the client to a doctor specializing in diseases of the ear.

The Federal Trade Commission is striving to wipe out these abuses and to end the misrepresentation that is so commonplace in the hearing aid delivery system. For example, the FTC has conducted a broad investigation which has culminated in complaints against six major hearing aid manufacturers. The complaints alleged that the manufacturers had engaged in false advertising, supplied false advertising materials to their dealers and retailers, and had participated in other unfair and deceptive acts and practices. All six manufacturers were charged with falsely representing in their advertising that they merchandise a hearing aid which is a new invention or involves new model features or new engineering or scientific concepts; that their hearing aids will be beneficial to persons with a hearing loss, regardless of the type or extent of loss; and that their hearing aids will enable persons with a hearing loss to distinguish or understand speech sounds in noisy or group situations. The manufacturers were also charged with advertising claims when there was no reasonable basis for doing so and failing to disclose the fact that many persons will not receive any significant benefit from the use of a hearing aid.

In addition to these misrepresentation charges, the Federal Trade Commission also filed other complaints against five of the largest hearing aid manufacturers, alleging that they had maintained a system of exclusive territories, restrained trade, fixed prices, and intimidated and coerced dealers to handle only their own brand of hearing aids and to exclude competing brands. According to the FTC, because of these practices, in some areas a particular dealer frequently had a virtual monopoly in the sale of hearing aids and intraband competition was eliminated. The result of this was an increase in retail prices. While complaints against two firms are still pending, three of the manufacturers have agreed to consent order.

Because of all of these abuses, the Federal Trade Commission has recently proposed a Trade Regulation Rule for the hearing aid in-

dustry. The proposed rule, which is similar to the recommendation of the HEW Intradepartmental Task Force, would require compliance with the following provisions:

1. A buyer has the right to cancel the purchase of a hearing aid within 30 days after delivery and pay only certain limited cancellation charges for a 30-day rental, including any custom ear mold delivered, and a 30-day supply of batteries.
2. A seller has the right to grant buyer more extensive rights than those mentioned in the Trade Regulation Rule.
3. Manufacturers are required to disclose the following material fact in any advertisement which makes a performance claim for a hearing aid: Many persons with a hearing loss will not receive any significant benefit from any hearing aid.
4. Certain representations concerning hearing aids, such as inaccurate claims by dealers that a retail outlet is actually a governmental, public service, or nonprofit medical, educational, or research establishment, are prohibited.
5. Certain selling techniques, such as visits to potential buyers for the purpose of inducing a sale without the prior consent of potential buyers, are prohibited.

Additional reform proposals have been made by the Food and Drug Administration. Besides the previously mentioned medical-clearance requirement, the FDA has poposed a hearing aid regulation which would require that certain instructions, warnings, and other information be provided to the hearing aid purchaser. The proposed regulation would require labeling and include the statement that a hearing aid will neither restore normal hearing nor prevent or improve organic conditions resulting in hearing impairment.

It is interesting to note that the National Hearing Aid Society, representing hearing aid dealers, has denied the abuses that have been documented by the FDA and FTC. In a letter to the subcommittee, the NHAS has taken the position that despite the allegations to the contrary and the FDA and FTC view that new regulations are needed, the present delivery system is working satisfactorily. The NHAS has argued that, "Most charges and accusations about the present hearing aid delivery system have not been documented by reliable research." Furthermore, the NHAS claims that its own national survey directly contradicts the criticism. For example, the 1974 survey shows that only 33 (18 percent) of the 184 hearing aid users studied reported having trouble and only four of these were difficulties which the hearing aid dealer was unable to solve.

Given the widespread abuses that have been documented in the hearing aid industry, it is understandable that the Subcommittee has found that hearing aid costs are excessively high and a formidable barrier to the millions of elderly who desperately need hearing assistance. The rteail price of most hearing aids ranged from $300 to $450 in 1972. The subcommittee believes that these high costs represent additional evidence of overpricing because these retail prices are over *two and a half times* the wholesale price. Further documentation that these prices are higher than need be, comes from the fact that the Veterans Administration, through its distribution system, has been able to provide hearing aids to those eligible for only $205 each (see Chapter V, delineating "Contract Purchasing"). The National Hearing Aid Society has defended this high mark-up and claims that it is due

to the fact that dealers supply a variety of other services, such as audiological tests, hearing and fitting, counseling about aid use, and maintenance in addition to the actual hearing aid.

The subcommittee believes that an open hearing aid industry is a vital prerequisite for lower costs to elderly consumers. The subcommittee is very concerned about the fact that, while there are about 50 manufacturers who sell hearing aids domestically, most of them have nowhere near the market control of the four largest manufacturers, who accounted for 50 percent of the dollar value of shipments in 1970, or of the eight largest manufacturers, who accounted for approximately 70 percent of shipments.

C. PAYMENT FOR HEARING AIDS UNDER EXISTING HEALTH BENEFIT PROGRAMS

The subcommittee has found that existing public and private health benefit programs provide virtually no coverage of necessary hearing services to our nation's elderly. Medicare, for example, does not pay for either hearing aids or hearing aid examinations. Similarly, the Medicaid program provides no coverage of hearing aids for the elderly in 39 states. Finally, present health insurance policies rarely provide any coverage of hearing aid costs. In short, the elderly, with the exception of those who are Medicaid eligible and lucky enough to live in one of the 11 states that does provide coverage, are forced to pay the excessively high costs of desperately needed hearing aids out of their own pockets.

CHAPTER IV—PROSTHETIC DEVICES AND OTHER DURABLE MEDICAL EQUIPMENT

A. EXCESSIVE MEDICARE PAYMENTS FOR OVERPRICED PACEMAKERS

Hearing aids, dentures, and eyeglasses are not only cases of medical appliances that cost too much for the millions of elderly people who need them. There are numerous other medical appliances of which this fact is true.

One of the most expensive prosthetic devices (taking the place of a part of the body) is the pacemaker. According to Dr. Sidney Wolfe, Director of the Public Citizen's Health Research Group, the actual production cost of a pacemaker is no more than "several hundred dollars." Yet, the current purchase price of the most commonly used pacemaker is a significantly higher amount, $1,300.00, according to the Health Research Group. Since Medicare does provide coverage for pacemakers purchased by the elderly, it is federal dollars that are paying for this excessively high markup in the price of pacemakers. The reason for this high markup is that:

> Price is not likely to become an important competitive element. The pacemaker is a vital device and a doctor bases his decision on confidence in the product rather than on price. Since Medicare pays for most pacemakers, the patient is also not concerned with the price. Thus, the demand for pacemakers is somewhat inelastic, providing little, if any, incentive for manufacturers to cut prices.[1]

[1] From the Research Dept. of Smith, Barney, and Company, New York.

In other words, rather than investigate the non-competitive pricing of pacemakers, the Department of Health, Education and Welfare, which is responsible for administering the Medicare program has continued to ignore the high cost of pacemakers and to spend $200 million of the taxpayer's dollars over the last 11 years on the over-priced devices. This is a violation of the Social Security Act (see 1814b and 1861v) which authorizes Medicare to pay only "reasonable costs" or "customary charges" for these devices. The Subcommittee condemns this fraud and is particularly shocked to find that the above explanation for the high price of pacemakers has been openly used by Smith, Barney and Company, a Wall Street firm, in order to encourage investment in Medtronics, a pacemaker manufacturer which accounts for about 60 percent of U.S. pacemaker sales. Because of this non-competitive pricing, Medtronics has had profit increases of 30 to 50 percent during each of the last 5 years, according to the Health Research Group.

B. UNNECESSARY MEDICARE PAYMENTS FOR DURABLE MEDICAL EQUIPMENT ITEMS

In addition to pacemakers, the subcommittee has found numerous other examples of medical appliances, such as hospital beds, crutches, wheelchairs, and dialysis equipment which are covered by Medicare and for which Medicare is paying excessively high amounts. This situation continues despite the fact that the 1972 Medicare amendments, Public Law 92–603, contained provisions to end these excessive payments. The Department of Health, Education and Welfare has not yet implemented those provisions.

Durable medical equipment (e.g. hospital beds, crutches, wheelchairs, and dialysis equipment) which is furnished to a Medicare patient for use in his or her home is covered under Part B of the Medicare program. If the equipment meets the program's definition of "durable medical equipment", is appropriate to the patient's condition, and meets the standard Part B deductible and coinsurance requirements, *Medicare will pay 80 percent of the cost of renting or purchasing the device. The choice of whether to rent or purchase the equipment is up to the individual who is receiving the coverage.* When the equipment is rented, payment is made monthly on the basis of reasonable rental charges. When the device has been purchased by the elderly person, Medicare will make payment either in a lump sum for an inexpensive appliance or in monthly installments for a costly one.

Since Medicare pays the cost of durable medical equipment whether it has been rented or purchased by the beneficiary, it frequently pays for the least economical way to provide the equipment to the elderly. The result is an estimated loss to the government of $9.5 million each year. Examples of this waste of taxpayer dollars have been reported by the New York Times. It cited the cases of a wheelchair that cost $168 to purchase, being rented for a total cost of $1,080, and a respirator that would have cost $396 to purchase being rented for $1,932. Additional documentation of this abuse has come from a 1972 General Accounting Office report to the Congress entitled "Need for Legislation to Authorize More Economical Ways of Providing Durable Medical Equipment Under Medicare." The report demon-

strated that *Medicare patients often rented durable medical equipment even when the periods of need, as estimated by their physicians, were long enough to justify purchase.*

During GAO's review of five insurance carriers in four states, GAO analyzed a statistical sample of patients' claims selected from the claims of the 13,000 patients whose claims for durable medical equipment were processed in 1970. For the 13,000 patients, GAO estimated that savings of $234,000—including the patient's share of $47,000—could have been realized if the equipment had been purchased when the anticipated periods of need indicated that purchases would have been more economical than rentals.

At a sixth insurance carrier in a fifth state, GAO analyzed a sample selected from the claims of the 7,000 patients whose claims were processed during August 1971. For the 7,000 patients, GAO estimated that savings of $763,000—including the patient's share of $153,000—could have been realized.

In line with the recommendations made by GAO in its report, legislation (Public Law 92–603) was enacted in 1972 which was designed to end the unreasonable expenses to the program resulting from unnecessary and costly rental of durable medical equipment. Under the legislation, the Secretary of Health, Education and Welfare was authorized to experiment with reimbursement approaches (in various geographic areas) which are intended to prevent those unreasonable expenses. HEW is also authorized to implement, without further legislation, any purchase approach that is found to be workable, desirable, and economical.

Congress has suggested that among the possible approaches to be evaluated would be the feasibility of suppliers contracting with the Secretary under arrangements whereby rental would be undertaken by means of lease-purchase arrangements providing for rental payments to terminate when an agreed upon total for purchase was reached under another approach, Medicare payment for a covered item of durable medical equipment would be made to the supplier in a lump sum where it was determined, in accordance with guidelines of the Secretary, that outright purchase would probably be more economical than lease-purchase; another approach would be to encourage beneficiaries to purchase used equipment by waiving the 20 percent coinsurance requirement where the purchase price of the used equipment is at least 25 percent less than the reasonable price of the item if purchased new.

The subcommittee is extremely disappointed to find that now, some four years after this legislation was enacted to end this waste of 9½ million taxpayer dollars each year as well as the waste of the limited money of the elderly, this abuse continues to rage because the Department of Health, Education and Welfare has still not implemented the provisions of this legislation and instituted more economical purchase approaches. While HEW has claimed that this delay was needed to design an experiment, the subcommittee can see *no reason* why HEW has delayed for *4 years* in implementing the legislation. HEW is currently conducting a "design of an experimental concept."

The lack of reason for a four-year delay is pointed out by the fact that the National Association of Blue Shield Plans, which represents the Blue Shield Plans that presently act as carriers for some 12 million Medicare beneficiaries, has informed the subcommittee that "several

of our plans are actively and eagerly seeking to participate in the durable medical equipment reimbursement demonstration authorized under Public Law 92–603."

C. HOME BLOOD PRESSURE MONITORING KITS

Another medical appliance which many elderly people purchase is the home blood pressure monitoring device. These devices have gone from a novelty mail-order item to a heavily purchased appliance available in drugstores. The reason for this growth in the use of home blood pressure monitoring units is the increased activity by government and health associations in publicizing the great danger of high blood pressure. This resulted in an increased public awareness and a greater demand for devices that a hypertensive person could use to measure their own blood pressure in their own homes. As public demand for the devices has increased, there has also been greater acceptance by doctors of the value of hypertensives using the devices, although many doctors continue to warn against patient use of the devices.

The blood pressure devices that are available in the United States fall into two categories: mercurial devices and aneroid devices. Each type has both advantages and disadvantages.

Manufacturers of mercurial devices (blood pressure monitoring units which make use of mercury to measure hypertension), such as Mr. John Baum, President of W. A. Baum Co., Inc., claim that these devices are the only accurate way to measure blood pressure. They argue that accuracy is the most important characteristic on which the device should be judged. As Mr. Baum said at a subcommittee hearing, "If an instrument is not accurate, and capable of remaining accurate it would not be a bargain even as a gift. Truly it is better not to have any blood pressure data at all than to have erroneous data."

On the other hand, distributers of imported aneroid devices (blood pressure devices which make use of gravity to measure hypertension) such as Mr. Alan Beeber, President of the Lumiscope Company, argue that aneroid devices, while not as accurate as mercurial devices, are certainly accurate enough for home use, since they do meet a federal accuracy standard of .3 millimeter. They claim that any difference in accuracy is not significant enough to justify the higher cost of mercurial devices. Because that price difference is so great (mercurial devices cost about $50 to $60 while aneroids cost about $25), aneroid distributors argue that practical consumers would be wise to purchase the less perfect but sufficiently reliable aneroid.

In short, the subcommittee has found that the elderly consumer who needs a blood pressure device has a choice between the mercurial and aneroid types with their possible differences in accuracy and price.

Regardless of which type the elderly consumer does choose, he or she must pay for the device out of his or her own pocket. Medicare, Medicaid, and private health insurance policies provide no coverage of home blood pressure monitoring units.

D. COVERAGE OF DURABLE MEDICAL EQUIPMENT UNDER MEDICARE FOR RESIDENTS OF INSTITUTIONS

Another omission of coverage under Medicare which needs correction concerns a provision of title XVIII which because of an error in

drafting or other oversight, has led to denial of coverage of certain durable medical equipment to residents of skilled nursing homes and intermediate care facilities.

Section 1861(s) of title XVIII defines "medical and other health services" as this term is used in the Scope of Benefits under Part B. Medical and other health services includes "durable medical equipment" defined in Section 1861(s)(6) as follows:

> (6) durable medical equipment, including iron lungs, oxygen tents, hospital beds, and wheelchairs used in the patient's home (including an institution used as his home other than an institution that meets the requirements of subsection (e)(1) or (j)(1) of this section), whether furnished on a rental basis or purchased.

The apparent purpose of the parenthetical language is to make these benefits available to persons making their homes in institutional settings as well as to persons residing in individual homes, but to exclude them from coverage under Part B when they can be covered under Part A. Subsection (e)(1) refers to hospitals and subsection (j)(1) refers to skilled nursing facilities which provide post hospital extended care services under Part A.

The problem is created by the fact that the exclusion is written in terms of the characteristics of the institution in which a person may make his home rather than in terms of the person's entitlement to receive the services through the institutional care covered by Part A. Many persons make their homes in institutions which meet subsection (j)(1) but who are not currently eligible for institutional benefits under Part A. These include, for example—

Patients in skilled nursing facilities who require skilled care but not in connection with a prior hospitalization;

Residents of intermediate care facilities. (Most ICFs "meet the requirements of subsection (j)(1)".)

The most serious manifestation of this problem is in denial of coverage for oxygen. Medicaid generally is not a resource. A few states, but very few, provide some oxygen under the heading of prescribed drugs, In general, however, the situation is that a person needing oxygen, who would be entitled to it under Part B if he resided in an individual home, has no access to coverage of oxygen because he makes his home in an institution; a situation contrary to the apparent intent of the original legislation.

The problem can be corrected by modifying the parenthetical language in Section 1861(s)(6) to clarify that the exception intended relates to persons entitled to the same benefits as a part of institutional care for which payments are being made under Part A.

The Social Security Administration/Bureau of Health Insurance has estimated the cost of closing this gap in protection to be between $1 million and $2 million per annum.

CHAPTER V—EXISTING CONTRACT PURCHASING PROGRAMS: EXAMPLES OF FEDERAL ASSISTANCE

In investigating the unmet need for medical appliances of the elderly, the subcommittee has found several exceptions to the virtual lack of meaningful assistance by the health benefit programs intended to meet such needs. These represent outstanding examples of action by government agencies to provide low-cost hearing aids, eyeglasses and dentures to thousands of people who require those devices. Most of these programs, such as those of the Veterans Administration, Defense Department, and General Services Administration, make use of volume contract purchasing to lower the cost of these appliances. These programs have been able to supply medical appliances for 40 to 500 percent below the cost of identical devices purchased from retail outlets. A thorough examination of these existing programs has demonstrated to the subcommittee that similar contract purchasing for our nation's elderly would mean an end to the high cost of their devices, would end many of the abuses that reduce quality and raise costs in these industries, and would help to answer the vast need of the elderly for medical appliances.

A. VETERANS' ADMINISTRATION CONTRACT PURCHASING PROGRAM

One of the most extensive volume contract purchasing programs is operated by the Veterans Administration. In 1975, for example, the VA supplied approximately 13,700 hearing aids and 21,000 eyeglasses. Because the VA purchases in large volume from the manufacturer that has made the lowest bid, these medical appliances were supplied at costs far lower than the general retail costs. The VA makes these appliances available to veterans in their hospital system or nursing homes and to service-connected veterans who need hearing aids.

In the Veterans Administration's program, eligible veterans who have hearing difficulties are first examined at one of the 171 VA hospitals by an ear specialist to determine whether medical or surgical treatment is appropriate. If a hearing aid seems appropriate, the veteran is usually referred to one of the 45 (in 1975) VA contract clinics for an audiological evaluation by an audiologist. When the VA determines that it is not feasible for a veteran to travel to one of the audiology clinics, he can be authorized to purchase an aid from a local dealer. In such a case, the examining physician must test the aid to be purchased on the veteran to assure that it is satisfactory.

The VA has developed a program for evaluating the more than 500 models that are available in the United States so that only those of the highest quality are selected for distribution. Each year the Veterans Administration invites manufacturers to submit their models for possible use by the VA. For example, in 1974, 19 hearing aid manufacturers responded to that invitation and submitted a total of 114 models for review. These models were submitted to the National Bureau of Standards which evaluated their performance characteristics. The Bureau of Standards then recommended specific models to the VA after consideration of their performance and cost.

The VA procures its hearing aids under two arrangements: hearing aids are purchased directly from the manufacturer for distribution to VA facilities; and where this is not possible, they are purchased from local dealers. Of the 13,700 hearing aids the VA purchased in 1975, about 95 percent were purchased directly from the 14 manufacturers participating in the program.

The subcommittee has found that the VA program has received favorable comments from several congressional committees and numerous consumer groups, such as the Public Citizen's Health Research Group, the Retired Professional Action Group and the Consumers Union. Perhaps most worthy of commendation is the fact that the VA program has consistently provided the hearing aids for extremely low prices. For example, for the current year the cost of the medical examination, hearing aid evaluation, overhead, depreciation of equipment, utilities, assembly of the hearing aid, and the hearing aid itself was estimated to be about $205 by the Veterans Administration. While the National Hearing Aid Society representing hearing aid dealers, has challenged these figures and claimed that the actual cost of a VA hearing aid ranges from $347.17 to $1211, it is important to note that the enormous cost savings under the VA program have been proven by the General Accounting Office.

GAO, an independent arm of the Congress, determined that it cost the VA an average of $199.90 or $5 less than the figure estimated by the VA, to issue a hearing aid. This includes all the costs involved. The subcommittee believes that the GAO figure completely refutes the National Hearing Aid Society claim and considers the price quite remarkable when compared to the average $350 cost to an individual purchasing a hearing aid privately from a dealer. In other words, *the VA, through contract purchasing, has been able to supply almost 14,000 hearing aids last year alone for more than 40 percent less than the general retail cost.*

The Veterans Administration also supplies eyeglasses to eligible veterans and purchases them direct from the manufacturer. They are currently contracting with Bausch and Lomb for this purpose. Under the Veterans Administration contract with Bausch and Lomb, the prescription is filled and the glasses assembled by the contractor at the time the prescription or prescriptions are submitted to them. Like the VA hearing aid program, the result of this contract has been that glasses are supplied at a cost far below the cost an individual purchasing glasses from a dealer would have to pay. The average price of glasses provided by the VA is $11 for single vision glasses with frames and case and $15 for bifocal glasses with frames and case. *The identical glasses sold on the open market cost around 50 or more than 350 percent more than the price the VA pays.*

B. DEPARTMENT OF DEFENSE CONTRACT PURCHASING PROGRAM

In addition to the Veterans Administration, there are other examples of this type of volume contract purchasing of medical appliances by government agencies. For example, the Department of Defense also contracts to purchase low-cost eyeglasses direct from the manufacturer that has submitted the lowest bid. The Department of Defense distributes the lenses, frames, and cases that it purchases to regional storage centers, which, in turn, distribute them to installations. The Department also operates regional laboratories which fill prescriptions

placed with them through the installations. The Department of Defense orders, for the most part, lenses of various powers and fills prescriptions from stock. Lenses are not ground by the Department of Defense or contractors at the time that the prescription is presented. The following prices were quoted to the subcommittee by a representative of the Defense Department Supply Agency in Philadelphia:

Single vision lenses, glass, pair	$1.00–1.05
Single vision lenses, plastic, pair	$1.80–2.00
Plastic frames	$1.00–1.05

The price range noted for the lenses indicates where the great majority of prices for lenses cluster. Some prices do fall outside the range, both below and above. For example, some glass lenses may cost as little as 85¢ and some may cost as much as $9. These costs constitute only a part of the total cost of eyeglasses since the glasses must be shipped to regional storage centers and dispensed through the regional laboratories.

The Defense Supply Agency has informed the subcommittee that the final cost of eyeglasses dispensed through the military system ranges from $7 to $8. This price is very similar to the price of glasses in the Veterans Administration program and again, much lower than the cost of eyeglasses purchased retail.

C. GENERAL SERVICES ADMINISTRATION CONTRACT PURCHASING PROGRAM

Another example of volume contract purchasing resulting in lower costs for a medical appliance is the General Services Administration's system of providing dental supplies to federal agencies. The General Services Administration negotiates with suppliers nationally, regionally, or locally to provide supplies on demand at negotiated prices. This enables such agencies as the Indian Health Service and the Uniformed Services to obtain dental supplies at considerably below the general cost to consumers.

The cost of false teeth represents the most extreme example of such cost differences. Laboratories which make dentures commonly purchase teeth in sections, putting the sections together to form plates. The sections will contain six each for the front teeth and eight for the rear teeth. Under the General Services Supply Schedule, federal agencies are given a 77.93 percent *discount* (therefore *actually paying* approximately 22 percent of the usual cost) on the purchase of porcelain "one by sixes," i.e., front teeth in sections of six. The suggested retail price of "one by sixes" purchased normally is $12.86. In sharp contrast, the federal agency price with this discount is $2.84. This represents a drop of approximately 500 percent. According to the Indian Health Service dental laboratory in Albuquerque, which has a contract purchasing arrangement with the General Services Administration, the cost of teeth is the single largest cost saving when comparing the cost of dentures made by the Indian Health Service and those made by commercial laboratories. Overall, the difference between the 1975 fiscal year costs of dental work performed by the Indian Health Service laboratory in Albuquerque and commercial laboratories in the same area was between 20 and 25 percent.

The General Services Administration has a similar program for the purchase of eyeglasses. The Indian Health Service, one of the agencies receiving glasses from the General Services Administration, has told the subcommittee that the estimated cost of eyeglasses under this program is approximately $18.

D. OTHER CONTRACT PURCHASING PROGRAMS

Another example of the lower costs that result from volume contract arrangements is the group purchasing plan operated for employees of the State of Michigan by that state. This program has been able to purchase glasses under contract for approximately $14, compared to average retail prices of about $35.

The subcommittee believes that the success of volume contract purchasing in lowering the cost of medical appliances has been proven numerous times. Existing examples have provided needed appliances for prices vastly lower than the cost when purchased by a lone individual from the dealer. Perhaps the ultimate proof of the value of these programs is that numerous consumer groups have enviously viewed the low costs that result from volume purchasing arrangements and have formed cooperatives. For example, in Michigan two such cooperatives have been formed of people, including many senior citizens, who have banded together to purchase the medical appliances that they need. The result has been significant reduction in the cost of the hearing aids and glasses that these cooperatives have purchased.

CHAPTER VI—CONCLUSIONS AND RECOMMENDATIONS

The Subcommittee on Health and Long-Term Care has investigated the needs of the elderly for eyeglasses, dentures, and hearing aids and the costs of these medical appliances. That investigation has demonstrated to the subcommittee that, in the area of medical appliances, the elderly are simply not receiving the high-quality health care that they are entitled to and that they so desperately need. For example, five million elderly Americans are wearing glasses which need correction. 3.4 million Americans over 65 have dentures which need to be replaced or refitted. Finally, 1.5 million elderly Americans are unable to hear words that are spoken in a normal voice and need either hearing aids or medical help.

In theory, public and private health benefit programs were created to meet this type of severe health need. However, in the area of appliances, these programs have been of only the most limited help. As this report has shown, Medicare does not cover the cost of eyeglasses, hearing aids, or dentures. Medicaid does cover these devices, but only in some of the states. Finally, private health insurance policies rarely cover eyeglasses and hearing aids and cover dental costs only occasionally. In short, elderly people who need medical appliances must either pay for them out of their own pockets or simply do without them.

The way to answer the vast unmet need of the elderly for medical appliances is for the federal government to become more active in helping the elderly in this area. The Subcommittee considers this increased federal assistance to the elderly vital; it is the only way to insure that the elderly have these vital health aids.

This federal assistance to the elderly could be provided in two ways: either as part of a comprehensive national health insurance program or separately, as an extension of Medicare.

RECOMMENDATION NO. 1—MEDICARE PART B SHOULD BE EXTENDED TO COVER EYEGLASSES, HEARING AIDS, DENTURES, AND RELATED MEDICAL CARE.

The subcommittee believes that in the absence of national health insurance, it is essential that legislation be passed which would extend coverage under Part B of the Medicare program to provide payments for: *dentures* (including the repair thereof and such dental services as are necessary to fit such dentures, including the extraction of teeth), *eyeglasses* (and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses or for the purpose of determining the need therefor), and *hearing aids* (including hearing examinations for the purpose of determining the need thereof).

An earlier subcommittee report, "New Perspectives in Health Care for Older Americans," recommended this extension of Medicare Part B. This report restates that recommendation and further docu-

ments its urgency. Legislation to authorize this extension, such as H.R. 12676, sponsored by Rep. Claude Pepper, and H.R. 12481, sponsored by Rep. Wm. J. Randall, should be enacted.

The subcommittee has found that the Medicare Part B extension could be quickly implemented by making use of existing Medicare administrative mechanisms. The additional coverage would represent no extra burden to those mechanisms. For example, the National Association of Blue Shield Plans, which presently acts as the carrier for some twelve million Medicare beneficiaries, has informed the subcommittee that their member plans "have the experience, the capability, and the willingness to administer any new form of properly designed medical appliance benefits for the aged."

With the extension, elderly people who choose to enroll in the voluntary Part B program by paying the premiums would be covered for these expenses. Once they spend more than $60 in a year on covered Part B medical care expenses, Medicare would pay 80% of the reasonable charges for the eyeglasses, hearing aids, and dentures that are determined to be medically necessary by a physician.

To finance the additional benefits, Part B monthly premiums and the federal contribution to the Part B program would be increased slightly. For example, by apportioning the costs of these new benefits in the same way as Part B costs were apportioned in 1977 (with premiums covering approximately 30 percent of program costs), the effect of the proposal would be an increase of $2.66 per month in the premiums paid by those elderly people who opt to participate in the program. Premiums would thus be increased from the present level of $7.20 to $9.86 a month.

With this small increase in monthly premiums, the subcommittee, with the assistance of the Department of Health, Education, and Welfare, has estimated that the cost to the federal government of operating the extended Part B Medicare program for eyeglasses, hearing aids, and dentures would be $1.9 billion per year. As is presently done with the federal share of the existing Medicare Part B program, the federal share of the costs of the program would be paid from general revenues. Thus, *the integrity of the social security trust fund will not be affected.*

These cost estimates are for the *initial year* of coverage. According to testimony presented to the Subcommittee at its June 23 hearing by the Department of Health, Education, and Welfare, during this first year of the program as well as the following 4 years, the cost of the program paid by the elderly in premiums and by the federal government would have to be maintained at these levels because of the enormous *backlog* of elderly people who are presently in desperate need of medical appliances. Thus, it is important to note that the cost paid by the elderly and by the federal government for this Medicare Part B extension, would decline drastically by the program's sixth year. That decline would be as much as *$1 billion* below the total first year cost of the program, depending upon the cost of inflation during this period.

Thus, the total first year cost of this Medicare extension would be $2.7 billion ($300 million for hearing aids, $600 million for eyeglasses, and $1.8 billion for dentures): the total annual cost after the fifth year would be reduced to approximately $1.7 billion (plus inflation).

With the extension of Medicare Part B, the subcommittee recommends that the Secretary of Health, Education and Welfare be directed to establish reasonable limits on the amounts that would be allowed for hearing aids, eyeglasses, and dentures and on the amounts

allowed for the related medical services. The Secretary should also be directed to establish such standards for participation of suppliers, and for the health items themselves, as he deems necessary in order to protect the health and safety of the patient and to help assure the effectiveness and propriety of the services and items that would be covered. In addition, the Secretary should be directed to establish, by regulation, such limitations and presumptions as to quality and quantity of devices as he may deem to be reasonable in order to prevent payment for items and services which may be unnecessary or excessive. This would include requirements for certification of medical need by a physician or other appropriate professional. It is important to note that present law (Social Security Act—Section 1832(a)(2)(b)) requires such certification of medical need by a physician before Medicare payment can be made for those appliances which are already covered by Medicare. Thus, there is a clear precedent for such a requirement for eyeglasses, hearing aids, and dentures as well.

The omission of coverage for residents of skilled nursing facilities and intermediate care facilities of certain durable medical equipment under Medicare, Section 1861(s) of title XVIII should be corrected. Modification of the parenthetical language in Section 1861(s)(6) to clarify that the exception intended relates to persons entitled to the same benefits as a part of institutional care for which payments are being made under Part A. The cost of such coverage is between $1 million and $2 million per annum.

RECOMMENDATION NO. 2—MEDICARE SHOULD UTILIZE CONTRACT PURCHASING WHERE FEASIBLE IN PROVIDING EYEGLASSES, HEARING AIDS, AND DENTURES TO THE ELDERLY.

While the subcommittee considers it imperative that Medicare benefits be extended, it considers it equally imperative that the extension not be done in such a way as to allow the inadequacies and overpricing of the present delivery system of medical appliances to continue. Indeed, it would be tragic if the Medicare extension would mean additional profits and rewards for those who would perpetuate the abuses of the present.

One way of insuring that a Medicare extension would not mean continued high costs for medical appliances is to use contract purchasing of these devices. As a result of convincing testimony during subcommittee hearings, the subcommittee recommends that volume contract purchasing of eyeglasses, hearing aids, and dentures be utilized by the Department of Health, Education, and Welfare to provide these appliances to the people who pay the Part B premiums. Existing contract purchasing programs, operated by the Veterans Administration, the Department of Defense, the General Services Administration, the state of Michigan, and others, are conclusive proof that this would lower the cost of medical appliances from the excessively high levels of the present.

The subcommittee recommends that legislation be passed instructing HEW to begin experimenting with volume contract purchasing as soon as possible. In addition, the legislation should make it the official HEW policy, to be gradually phased in within the next 5 to 10 years, that volume purchasing be used wherever feasible, to provide eyeglasses, hearing aids, and dentures to those covered by the Medicare

extension. The subcommittee also recommends that states consider making use of contract purchasing of medical appliances, as part of their Medicaid programs.

Such a contract purchasing program might work in the following way: manufacturers of medical appliances would be invited to bid by submitting models of their appliances, the lowest price at which they could provide the devices through retail outlets to those eligible, and information concerning the number of retail outlets that distribute their devices. The Secretary of Health, Education, and Welfare would then, on the basis of those bids, choose among the manufacturers and contract with as many of them as necessary for large volume purchases of the devices. It is important to note that it would not be necessary to contract with only a limited number of companies in order to enjoy the cost reduction that results from large volume purchasing. Here, the existing purchasing program operated by the Veterans Administration serves as a clear precedent: for example, in 1974, the VA contracted with *14* different manufacturers for the purchase of a total of 13,700 hearing aids. The result of these contracts was that the VA was able to supply hearing aids for an average cost of about $200, drastically lower than the average $350 retail hearing aid cost.

The manufacturers that are awarded the contracts would be responsible for providing the appliances, for the stipulated price, to retail outlets. The retail outlets would then distribute the appliances to elderly consumers who have paid the Part B premiums. Medicare payments to the retailers would be based on:

> The lower range of estimated acquisition costs incurred by the individuals who provide the newly covered items to the patient on an economical basis; plus
>
> A fee for the dispenser of the item which is sufficient to compensate the more efficient suppliers and providers for the services rendered.

Elderly consumers who are covered by Part B and who did not want to purchase their health aids from these manufacturers, could purchase their hearing aids, eyeglasses, and dentures from other companies. In that case, they would receive reimbursement from Medicare for the price that the identical device would cost when purchased through the contract program. They would not be reimbursed for the difference between the lower contract purchase price and the higher open market charge.

This system, in addition to lowering the cost of the appliances, would still allow elderly consumers the *freedom of choice* to determine whether or not they want to participate in the program. Since this system would allow consumers the choice of buying a device from a contract outlet or not, the Subcommittee has found that it would be consistent with Section 1802 of the Social Security Act which guarantees patients the free choice of providers of Medicare services.

By the same token, manufacturers who did not wish to participate in the program or who were not selected for the program would still be free to provide covered services. In this case, they could not bill Medicare directly. They would bill the patient for the agreed price. The patient, if covered by Medicare Part B, would receive the limited reimbursement described above.

Finally, it is important to note that there is a clear precedent for HEW's use of such reimbursement limits. The 1972 Medicare legislation provided for payments for items of durable medical equipment to be based on the lowest charge level at which they are widely and consistently available from local suppliers. In addition, as of September,

1976, HEW is implementing such a measure concerning drugs purchased through the Department's various health service and health benefit programs. As part of this effort, the government's reimbursement to pharmacies is being limited to the estimated acquisition cost of the drug to the pharmacist plus a dispensing fee.

RECOMMENDATION NO. 3—A SERIES OF SAFEGUARDS SHOULD BE ENACTED TO END ABUSES AGAINST ELDERLY MEDICAL APPLIANCE CONSUMERS.

In its investigation of the hearing aid, eyeglasses, and denture industries, the Subcommittee has seen numerous examples of the abuse of consumers purchasing these health aids. For example, as this report has demonstrated, in the hearing aid industry alone, there is evidence of inadequate training of dealers, anti-competitive practices, anti-trust violations, misrepresentation, and the sale of unnecessary hearing aids to unwitting consumers by those dealers. The Subcommittee thus believes, that extending Medicare coverage and the use of contract purchasing represent only part of the solution. They alone will not insure that these abuses will no longer be a part of these industries.

The subcommittee recommends that a series of major safeguards be enacted in this area to protect elderly consumers from the kinds of abuses that they suffer today. Only through these positive actions can we genuinely insure that the elderly will receive the highest quality medical appliances and medical care.

The first of these safeguards is continued and increased scrutiny of these industries by the federal agencies which have the responsibility of overseeing these industries and protecting the consumer. For example, the subcommittee again requests, as the chairman did in the subcommittee's June 23 hearing, that the Federal Trade Commission investigate unreasonable charges in the hearing aid, eyeglass, denture and pacemaker industries. A thorough investigation is vital in order to stamp out the anti-competitive activities and anti-trust violations that may be widespread in that industry, as discussed earlier in this report.

Another example of an area which requires increased oversight by a federal agency is the home blood pressure device industry. The subcommittee urges the Food and Drug Administration to determine the accuracy of aneroid and mercurial devices and to issue minimum standards of accuracy with which blood pressure devices must comply in order to be available for purchase.

The second safeguard that the subcommittee advocates is action by the individual states or a national Federal Trade Commission regulation to end price advertising bans on these devices. Presently, only four states (Texas, Florida, Virginia, and Massachusetts) allow such price advertising. Analysis by the Federal Trade Commission's Bureau of Consumer Protection has demonstrated that such bans "reduce competition, restrict consumer access to information, and allow higher than competitive prices to exist." The best example of this is eyeglasses, where a lack of advertising has led to little consumer knowledge of the incredible 200 to 300 percent variance in the price of glasses.

This lack of information about low- and medium-priced eyeglass retail outlets is particularly harmful to the elderly. There are two reasons for this: First of all, many elderly people have very limited and often fixed incomes. They cannot afford to waste limited dollars on overpriced medical appliances. The excessively high price may actually prevent an elderly person from obtaining a desperately needed health aid. Second of all, many elderly persons are severely limited in the scope and range of their mobility and activities due to chronic illness. As such, they are unable to engage in the kind of "comparative shopping" that would help them find lower prices. Thus, they have a special need for accessible price information through advertising.

The third set of safeguards are needed to eliminate those Medicare expenditures which are excessive and unnecessary. First of all, the Department of Health, Education, and Welfare should immediately implement leasing or other economical methods of obtaining medical equipment. Legislation authorizing this was passed four years ago and HEW is only now beginning to "design an experimental concept" in this area. The subcommittee can see no reason for the delay and the continued waste. Furthermore, the Subcommittee urges HEW to closely scrutinize the costs that Medicare pays for health aids already covered by Medicare. HEW should impose reimbursement ceilings and pay only "reasonable charges," as mandated by the Social Security Act (see 1814b and 1861v). It should not subsidize the enormous profits of pacemaker manufacturers, for example, and ignore obvious overpricing. The Department must begin to conduct oversight of payments to these industries.

Other HEW actions that are needed in order to end abuses of Medicare covered medical appliances include audits, at least on a random basis, of medical appliance manufacturers and providers. These audits should investigate the possible use of hidden discounts and other types of fraud. To conduct these audits, HEW, through its Bureau of Health Insurance, should adequately train existing personnel or hire other personnel who can perform such procedures. If on the basis of such an audit, a manufacturer, provider, or if a consumer is found to have defrauded Medicare or the public in this area, they should be subject to a uniform system of quick and severe penalties. The penalties should be developed in conformity with due process and existing criminal and civil codes.

In addition, HEW should promulgate regulations or guidelines which would reinforce the freedom of choice of Medicare recipients among health care providers as guaranteed in Section 1802 of the Social Security Act. One way to maximize the effect of this freedom of choice provision would be to allow provider agencies to prescribe the type and essential specifications of equipment needed by the patient and perhaps suggest a range of brands that met these requirements, but allow the consumer to purchase his own equipment. The involvement of individual providers or provider agencies in controlling significant portions of the medical appliance industry through their ability to refer cases as part of home care for a patient would thus be limited. Present procedures lack checks and balances in this area and might lead to elimination of marketplace control of medical appliances as well as overbilling, hidden discounts, rebates, and overutilization. Home health agencies and medical providers may add automatic service or overhead charges in connection with

a single medical appliance manufacturer in furnishing the equipment to the patient. It is important to note that in implementing the safeguard, care must be taken so that the new procedures will not in effect take away benefits from beneficiaries. The subcommittee thus believes that the steps taken to protect freedom of choice must either concern administrative expenses such as multiple related overhead operations or a reasonable alternative approach of eliminating the provider agency as middleman.

Finally, HEW should mandate cross referencing of prevailing rates, in order to create a profile of prices in a particular area, by all Part A and Part B intermediaries. The intermediaries would then know the maximum amount payable in an area and would have a profile of what each medical equipment supplier charges. This action would make payments largely conform to "prudent buyer" guidelines. The Part A intermediary would know the maximum amount payable to the supplier under Part B. The Part B intermediary would know what a supplier is charging agencies for inclusion in the computation of the supplier's profile.

The subcommittee believes that there is an especially severe need for a series of safeguards specifically directed at ending the inadequacies of the present hearing aid delivery system. As representatives of the American Speech and Hearing Association stated in testimony submitted to the subcommittee:

> A preoccupation with profit significantly diminishes the (hearing aid) industry's potential to serve and generally benefit the health and welfare interests of hearing-impaired Americans. Industry efforts toward responsible, genuine self-regulation have failed miserably. Attempts to achieve the kind of industry-professional consensus which might have made these regulations unnecessary also have been unsuccessful. Clearly, the time has come for the imposition of responsible industry standards by the federal government.

One example of such a responsible standard that should be imposed by the Federal Government is the proposed FTC regulation that *hearing aid purchasers must have the right to return hearing aids.* Another example of a badly needed standard is the proposed regulation that would *require hearing aid manufacturers to label their advertising with the following disclosure: "Many persons with a hearing loss will not receive any significant benefit from any hearing aid."* A third example is the proposed regulation which would *make it illegal to use certain techniques in selling hearing aids.* For example, door to door sale of hearing aids without the consent of the prospective buyer would be barred. The subcommittee endorses these three proposals as vital in order to reduce the large number of consumers who end up stuck with hearing aids for which they have spent hard earned dollars and which provide no improvement in hearing. Thus, the subcommittee recommends that the Federal Trade Commission, which has proposed the regulations, implement the proposals as soon as possible.

In addition, the subcommittee considers it essential that the Food and Drug Administration promulgate a regulation which would *require prior examination by a physician, preferably a hearing specialist, to purchase a hearing aid.* The present lack of any such requirement is the chief cause of the millions of dollars that are wasted for hearing aids that can be of no help. The subcommittee rejects any solution to this problem that does not include a medical clearance requirement

which would be binding on everyone except where specific exemptions are allowed. Thus, it condemns the proposal by the Food and Drug Administration which would allow anyone over the age of 18 who does not have certain symptoms simply to waive the required examination. While the waiver's proponents argue that it is needed because people in some rural areas have no access to medical care, the subcommittee believes that this is not sufficient reason to allow everyone the right to waive the requirement. The subcommittee favors a different approach to this medical clearance issue. It favors exemptions to the requirement where they are needed (for example when an individual lives in a rural area where there is no access to a doctor or when an individual's religious beliefs forbid an examination by a physician) but believes that *all those not specifically exempted on these grounds should be required to see a doctor, preferably a hearing specialist, before purchasing a hearing aid.* Thus, the FDA's current proposal negates the requirement for medically determined need on the grounds that the requirement may be inappropriate for a handful of Americans. A much more logical approach would be to simply exempt such persons for whom medical clearance might not be appropriate, but to maintain the requirement for everyone else. Thus, the subcommittee considers the FDA proposal inadequate.

Finally, the last of the series of safeguards needed in the hearing care area is increased assistance by the Federal Government through the Department of Health, Education, and Welfare, to encourage continuing education and training programs for hearing specialists, clinical audiologists, and physicians in order to improve the quality of the hearing care they provide. Similarly, state and local public health departments should be encouraged by the Federal Government to provide greater hearing care to the elderly, including a network of examination and treatment sites.

RECOMMENDATION NO. 4—THE SUBCOMMITTEE RECOMMENDS THAT ALL PEOPLE PURCHASING EYEGLASSES, HEARING AIDS, AND DENTURES USE CONSUMER DISCRETION TO AVOID ABUSES SUCH AS OVERPRICING AND UNNECESSARY SERVICES.

In its investigation of the delivery system of medical appliances, the subcommittee has found numerous suggestions that consumers can use to avoid overpriced delivery and unnecessary services. The subcommittee recommends that people purchasing medical appliances make use of these "consumer tips" in order that they will have eyeglasses, hearing aids, and dentures that are of the highest possible quality and the lowest possible price. In addition, where appropriate, the federal government and regional and local authorities should disseminate such information to consumers. These suggestions are not intended to serve as a complete listing, but are ones which the Subcommittee felt might be useful to consumers. Some general suggestions include:

1. If you are not eligible for participation in an existing contract purchasing program (see Chapter V—Existing Contract Purchasing Programs: Examples of Federal Assistance) you might wish to form your own group of consumers with similar needs. Such groups can save large amounts of money on medical appliances by purchasing in large volume.

2. Be a comparative shopper so that you can find the medical appliance that you need for the lowest cost at which it is available. In states where price advertising of these devices is legal, use these publicly posted prices as part of your comparative shopping and encourage all retailers in these areas to advertise their prices.

More specific suggestions for purchasing medical appliances include:

Eyeglasses

1. When having your eyes examined by an optometrist or opthamologist, make sure that the examination is thorough. It should include questions concerning your complete case history and tests for near, distant, dépth, peripheral, color, and unaided vision. Eye coordination should also be tested. Also, be sure that the atmosphere of the examination is professional and not that of a hurried selling job. Check to make sure you are not asked to examine eye charts under conditions that might make those charts appear unclear such as an unfocused slide or a poorly lit room.

2. After the examination, don't simply accept what is suggested. Insist on asking questions if you have them. For example, if you already wear glasses and are told that you need a new prescription, ask about the amount of change between the old prescription and the new one. If the change is a small one (something under half a measure called a diopter) you might wish to get a second opinion about the need for new glasses.

3. Get the prescription from the opthamologist or optometrist who has examined your eyes. Then begin comparative shopping to find the optometrist or optician who can provide the necessary glasses at the lowest price. Keep in mind the tremendous variance in the cost of identical eyeglasses. You might wish to consult friends or physicians for their suggestions of where inexpensive glasses can best be purchased.

Dentures

1. Before buying dentures you need to choose a dentist. "Shop around" for the best one. Consult your family physician for his recommendation of a good dentist. You might also wish to get recommendations from the faculty of a local university's school of dentistry. Finally, in some areas, public-interest groups have compiled directories of dentists, listing facts about their backgrounds and practices which would be helpful in selecting a dentist.

2. Consider getting dentures at a low-cost dental clinic. Many dental schools, for example, operate such clinics.

3. Once you have selected a dentist, make sure that you are receiving a satisfactory examination. For example, good dentists will inquire about your medical and dental history and will thoroughly examine external structures, teeth, and gums.

4. Insist that the dentist provide an estimate of fees before any treatment is given and an itemized bill afterward. Do not be afraid to ask for this information before you receive dental care.

5. Finally, you should insist that before any steps, such as extractions, are made, the dentist should go over the situation with you. He should discuss alternative methods of treatment based on his examination of the condition of your mouth. Make sure that you are satisfied with his explanation before you invest in expensive dental care.

Hearing Aids

1. Before purchasing a hearing aid, have your hearing examined by an otolaryngologist (ear, nose, and throat specialist) or an otologist (ear specialist). These people are physicians and have the expertise and impartiality to determine whether or not a hearing aid is needed. Hearing aid dealers do not and, unfortunately, may sometimes prescribe unnecessary or incorrect hearing aids when alternative treatment or no treatment is in fact required.

2. Be extremely skeptical of hearing aid advertisements which announce "the latest electronic wizardry" and guarantee that the aid will "return your hearing to normal." These claims may be just that—claims. In this regard it is interesting to note that Consumer Reports Magazine has concluded that hearing aids available today are "no better," so far as performance affecting speech intelligibility is concerned, than aids tested in the pre-transistor days of 1951.

3. Before purchasing a hearing aid, check with the dealer and see what guarantee comes with the aid. A few dealers do offer a money-back agreement to consumers (if a dealer does agree to a money-back arrangement, make sure you have him put it in writing). Most dealers, however, will only allow unsatisfied consumers to exchange hearing aids.

4. In deciding which hearing aid to buy, do some comparative shopping. Don't be afraid to compare the cost of the devices among different dealers. This will assist in avoiding overchanging.

5. Once you have purchased a hearing aid, go through a period of training in order to get the best use of the aid. The hearing aid itself is not enough. Either an audiologist or a dealer can teach you how to best use your hearing aid in different situations. In addition, you can receive further training in lip reading and other skills that will improve your hearing comprehension at a hearing clinic.

GLOSSARY

ACO—American College of Otolaryngology, the national organization that represents physicians who specialize in care of the ear, nose, pharynx, and larynx.

ASHA—American Speech and Hearing Association, the national organization that represents audiologists (defined below).

Audiologist—A person who has a master's degree or the equivalent in the rehabilitation of those whose impaired hearing cannot be improved by medical or surgical means. It is important to note that by law, audiologists cannot provide medical examinations or care.

Edentulous—Without natural teeth.

Hearing aid dealer—An individual who fits, sells, and services hearing aids. Some have completed a 20-week home-study course, passed an examination sponsored by the NHAS (defined below), and been certified by the NHAS.

Hearing specialist—A physician who specializes in hearing disorders. See "otolaryngologist" and "otologist."

NHAS—National Hearing Aid Society, the national organization that represents and provides home-study training to hearing aid dealers.

Opthamologist—A physician who specializes in the diagnosis and medical and surgical treatment of diseases and defects of the eye and related structures.

Optician—An expert who deals in the science, craft, and art of optics as applied to the translation, filling, and adapting of opthalmic prescriptions, products, and accessories.

Optometrist—A person trained and licensed to examine and test the eyes and to treat visual defects by prescribing and adapting corrective lenses and other optical aids, and by establishing programs of exercises.

Otologist—A physician who specializes in that branch of medicine which deals with the ear, its anatomy, physiology, and pathology.

Otolaryngologist—A physician who specializes in that branch of medicine which deals with the ear, nose, pharynx and larynx, and their diseases.

Periodontal disease—Disease of the bone and tissue supporting the teeth. A common dental disease among the elderly.

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